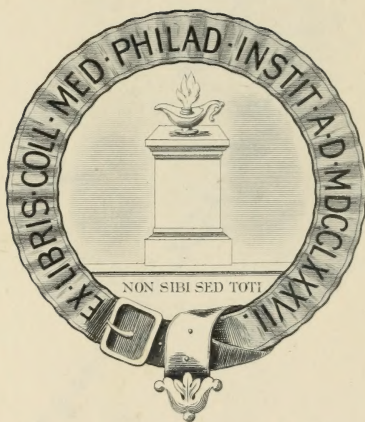





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The HAHNEMANNIAN Monthly.

(VOLUME THIRTY-FOURTH.)

JANUARY TO DECEMBER,
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EDITED BY
WM. W. VAN BAUN, M.D.

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THE HAHNEMANNIAN MONTHLY.

JANUARY, 1899.

CLINICAL LECTURE.

BY CLARENCE BARTLETT, M.D., PHILADELPHIA.

(Delivered at Hahnemann Hospital, December 9, 1898, and reported by F. E. Wessels,
Medical Stenographer.)

CASE I.—TYPHOID FEVER MISTAKEN FOR CHRONIC LEAD POISONING.—The first case which I bring before you can hardly be called a nervous one. Inasmuch, however, as it presented important neurological aspects, and owing also to the doubts thrown upon its nature, it was referred to me for an opinion by one of our visiting staff, the impression being that it was one of probable lead poisoning. The patient is a Dane, 34 years of age, a painter by occupation. His family history is excellent; his own personal history is good, with the exception of the fact that he has suffered from lead poisoning several times. He was admitted to the hospital on November 29th. On October 29th he states that he was taken with pains in the abdomen, constipation and severe headache, the pain in the head being especially severe. It was constant, and tortured him day and night, so that he got but little sleep. On his admission the abdominal pain was still present, though moderate, but his headache remained severe. Physical examination showed a blue line along the gums. This he has at the present

time, but that blue line is not as prominent a feature of the case as it was when he was admitted. I notice it best marked over a little ulceration beneath one of the lower central incisors. No blue line whatever is observable along the gums of the upper jaw. So much then for the history of the case, and the data which suggest lead poisoning.

Since our patient has been in the hospital he has presented a noteworthy temperature curve. He has had high fever, with evening exacerbations and morning remissions. The minimum morning temperature (until this morning) has been 100° F., and the maximum evening temperature has been 104.8° F. Last evening his temperature was 102.2° F., and this morning but 99.2° F. During the past seven days there has been a steady decline in the fever. I will pass this temperature chart around the class that you may see at a glance the course taken by the fever. When he was first admitted his pulse rate was but 100; during the past few days it has ranged from 74 to 90.

The question next comes up, "What kind of case is it we have before us?"

The patient was referred to me as one of lead poisoning, the supposition being that he suffered from what we call lead encephalopathy; that is, an affection of the brain dependent upon lead poisoning. Let us then start upon this theory, and consider whether the case can be one of lead encephalopathy. Lead is perfectly capable of producing severe headaches, but I know of no record of a case of lead poisoning in which there existed such prolonged high temperature following the course noted in this patient, and especially so when we find the pulse so disproportionately slow to the rise in temperature. Lead encephalopathy is characterized, as a rule, by headaches, delirium, and even mania. In other words, the cerebral symptoms of lead encephalopathy are far more severe than those observed in this case. When lead poisoning has progressed to the extent of producing such marked headache as the one from which our patient suffered, we should find extensive kidney disease, and this renal affection should be accompanied by high arterial tension. An examination of the urine shows a well-marked reaction of albumin, specific gravity 1017, chemical action acid, urates in abundance, but no casts. Still further, Dr. Jes-

sup has made an ophthalmoscopic examination, and reports pallor of the optic disks. The usual presence of marked anæmia in chronic lead poisoning suggested a blood count, with the result that I find 6,000,000 red corpuscles to the cubic millimetre. We are therefore safe in saying that there is no anæmia, for he has a half-million more red cells to the cubic millimetre of blood than the normal standard calls for. Summarizing from the above, we have in favor of lead poisoning the occupation of the patient, his previous history of lead poisoning, abdominal pains, constipation, albuminuria, and pallor of the optic disks. These I will show you presently are outweighed by clinical evidence, pointing indisputably to another affection, though it is evident from the blue line on the gums that he is suffering to some extent from lead poisoning. Remember, however, that the blue line remains long after other symptoms have disappeared, and may be related to previous attacks.

Can the case be one of inflammation of the membranes of the brain, or can it be a cerebritis? Such a condition can exist only as a result of one of the well-known causes of these diseases, namely, traumatism, middle-ear suppuration, metastasis and tuberculosis. Careful examination gives no history of any of these ætiological factors. Furthermore, I have examined his knee-jerks, and find them normal; the pupillary reactions are normal; there is no paralysis; the cranial nerves all functionate normally; indeed, the only symptom to suggest brain disease is the severe headache. The strong negative evidence above mentioned fully outweighs this one symptom.

Now we do have a very satisfactory explanation of the nature of this trouble on the supposition that our patient has typhoid fever. I believe that typhoid fever will account for nearly every symptom from which he suffers. In the first place, he has enlargement of the spleen, which, as you observe, is well marked on percussion. We find also that he has two characteristic spots of typhoid eruption on his abdomen. His fever is that characteristic of typhoid. His pulse is of low tension, as we find in most uncomplicated typhoids. It is hardly likely, in view of the microscopic examination, that the albuminuria is anything more severe than the congestive or toxic variety, which is often associated with acute febrile disorders.

You will see from this that I have made out a strong argument for the case being one of typhoid. Additional inquiry as to his occupation tells us that he has been a fresco-painter of late, and that he uses water-colors. Artisans of this class do not use paints as carelessly or in as large quantities as do house-painters, and hence are not so liable to poisoning.

Dr. Goodno was asked to examine this patient and give his opinion. I was handed a note from him as I entered the clinic. He says that the case can be nothing else but typhoid fever.

The conclusion thus reached calls for a change of diet which our patient does not relish. He must be limited to liquid food, although he is better. Bryonia suggests itself as a good remedy; but with his treatment I have nothing to do, as I must refer him back to the medical side of the hospital.

CASE II.—SYPHILITIC INFECTION; HEMIPLEGIA; DISTURBED MENTALITY.—Here is another case of general medical as well as of neurological interest. This patient came to us on October 28th. He is 60 years of age. Like our preceding patient he is a painter by occupation. His parents died of old age. There is no history of family peculiarities, and no nervous diseases in either himself or relatives. He himself has suffered from all the diseases of childhood and intermittent fever; he had influenza in 1896. He has also had pneumonia. Four or five weeks before admission to the hospital he was taken sick (so he says), since which time his mind has been disordered. We find that any information given by him is decidedly unreliable. From others I learn that a few days before admission he was taken suddenly with left hemiplegia, which disappeared so promptly that when we saw him he was apparently free from his paralysis. Mentally, however, he was decidedly deficient. He is very contradictory in his statements. For example, he admits syphilis, but one time he tells us that infection took place eighteen months ago, and at another he spoke of it as occurring in 1890. We would therefore be perfectly justified in throwing out such a history altogether were it not for the fact that I found on both hands well marked palmar syphilides of the squamous variety. These have disappeared under treatment by mercury. On the lower extremities he has some old pigmented scars suggestive of healed syphilitic lesions.

Dr. Shallcross has examined his nose and throat, and finds tertiary ulcerations. Repeated examinations of his urine show sugar to be present. This varies in quantity from day to day. On October 28th it was two grains to the ounce; on November 6th, five and one-third grains to the ounce; on November 15th, three and one-quarter grains; on November 30th, four grains. Yesterday and to-day he has been on an exclusive milk diet, and each ounce of urine contains less than two grains. The case may be summarized as follows: Old syphilitic infection; suddenly appearing hemiplegia, which, however, was not permanent; mental disturbance which has continued up to the present time; and glycosuria.

It remains for us to decide whether the relation of his paralysis and other cerebral symptoms are due to his age, to syphilis or to glycosuria. I believe that in this case the syphilitic factor is the important one. In favor of syphilis being the active ætiological agent, we have the rapid improvement of his cutaneous symptoms under mercury, and to his greatly improved mental condition. At one time his mental condition was very bad indeed. His mind was wandering constantly. He is still far from well; but I can show you his present condition by asking him a few questions.

Q. Where have you been this morning?

A. (Patient's answer inaudible; apparently a mumble.)

Q. Where were you yesterday afternoon?

A. I was in a hospital way up town.

Q. Where were you yesterday morning?

A. I was in the country, some hospital out there.

This man has delusions as to his location. I visit him each day, and he tells me each time that he has just come in, that he has been to a hospital up town, or that he has been in the country, or that he visited a friend. And yet he has not been outside of our building for some days.

The lesion was one of sudden onset; hence it must have been circulatory, probably hæmorrhage dependent upon syphilitic or atheromatous degeneration of blood-vessels. Examining his radial arteries, I find them presenting no evidence of atheromatous changes. I therefore incline to the belief that the arterial disease is syphilitic. The case, then, is one of intracerebral hæmorrhage or apoplexy. But why has it behaved so differently from the ordinary apoplectic case? Simply be-

cause the hæmorrhage took place into a portion of the brain which subserved mental and not motor processes. In the beginning there was paralysis, probably because the suddenly-appearing pressure exerted an influence upon more remote structures. Motor fibres themselves not being injured, and the structures accommodating themselves in a measure to the new condition of affairs, the paralysis disappeared. The mental symptoms which remain are undoubtedly due to hæmorrhage into the right frontal lobe.

What about the glycosuria? Concerning this I can say but little. He has none of the ordinary symptoms of diabetes, as emaciation, polyuria and thirst.

This case should now be treated with potassium iodide, but unfortunately we are unable to determine the result of such a course, as he leaves us this afternoon.

CASE III.—PAIN IN RIGHT THIGH; SUPPOSED SCIATICA.—The next patient is a case that was referred to me as one of sciatica, but it is not sciatica. The patient is a man 69 years of age, a farmer by occupation; his father died of consumption; his mother died with jaundice; he himself has had various diseases; he has had shingles; he suffered from "grip" six years ago, from which he thoroughly recovered. About ten years ago he had what was called "rheumatism in the right leg." This disappeared, but returned again six years ago. The pain then began across the back; he says that it started from a strain. This pain kept working on down the back until it reached his hip, and now the pain runs down the leg to the ankle, especially in the morning when he first gets up. It is not a steady pain, but comes and goes quickly. He also says that he can lie much easier on the left side than he can on the other. At times he relieves himself by firmly pressing on the leg and back. He cannot walk in the dark, and when asked if he can walk with his eyes closed he says he won't dare try it. He has noticed he cannot stand while his eyes are closed.

The physical examination shows nothing, according to the notes. Pulse, 58; temperature, 97.8° F., and at times has risen since then to 98.8° F. At no time has his pulse been over 64; quantity of urine in 24 hours runs about 34 ounces. Examination of the urine by Dr. Dobson shows sp. gr. 1025, acid reaction; negative as to albumin and sugar. There is the case as far as the history is concerned, and it was supposed to

be sciatica; this is the reason I have the case to bring before you. Now, I ask him where his pain is. You see his hand goes pretty well around anteriorly, as well as posteriorly.

Q. How far up does the pain extend?

A. (Patient): Not much farther (referring to hip).

Q. All the way down to the ankle and in front also?

A. (Patient): Yes, sir.

Now, you see you have pain extending all the way around the hip, anteriorly as well as posteriorly. If it was sciatica the pain would be limited to the area of distribution of the sciatic nerve and would not be found in front, as in this case. Let us look at his position as he lies in bed. You notice he keeps the leg flexed at the knee and drawn up at the hip; he does this for relief. If now you observe carefully, when I move the leg and endeavor to straighten it, you will notice that there is a rigidity at the hip-joint. This affects the arching of the back. It is not necessary, as in ordinary cases, to lay my hand underneath to feel the back arch up. You know that this cannot occur when there is no rigidity. Now, the trouble is evidently in the hip-joint. We can say, then, that it is not sciatica, or the hip-joint would not behave in that way. I examine his pulse, and what do I find? I find the radial artery a rigid tube, atheromatous to an extreme, and this is the result of his age; he is 69 years of age. I find, moreover, arcus senilis, but it is not well marked. We have, then, evidence of degeneration. This man probably has one of those chronic articular inflammations dependent upon increased formation of the fibrous tissue in the joint. This condition is evidently widespread.

The question comes up, What can be done for a case of this kind? He has been to several doctors who have felt every confidence in their ability, but all have failed to cure him. "Rheumatism," (?) such as this, is a difficult thing to cure. In some cases you cannot do anything for it. In others it is impossible to cure or relieve without long and patient effort. I consider, however, that mechanical measures are of the greatest importance in a case of this kind, and if his finances were such that he could have systematic massage of that hip-joint I should feel that much could be done for him; but he cannot have it, and for that reason I feel that we are obliged to rely exclusively upon medication, the medicine upon which I would rely being rhus tox., 1x.

SUPRAPUBIC LITHOTOMY IN AGED MEN—REPORT OF TWO CASES.

BY SIDNEY F. WILCOX, M.D., NEW YORK.

(Read before the Interstate Homœopathic Medical Association at Scranton, Pa., Oct. 11, 1898.)

AMONG the distressing complaints from which some very old men suffer is stone in the bladder. In these cases the disease may be directly traceable to that troublesome accompaniment of old age—enlarged prostate. The great size of this gland favors the retention of residual urine and the deposition of sediment, with the consequent formation of stone. When a man over seventy-five years of age is found to be suffering from stone in the bladder, it is a question of some importance to decide what form of relief shall be offered him. The crushing operation is generally impracticable at this time of life, while any form of perineal operation is difficult on account of the prostatic enlargement. So the suprapubic method seems to be the only one left.

The question as to justifiability of this operation was at one time one of the grave points of dispute among surgeons; and the surgical literature of a generation ago contained many articles on the subject, pro and con, and to Prof. Wm. Tod Hel-muth is largely due the credit of popularizing what was then an unpopular operation. At that period the weight of opinion was against the operation on account of certain dangers attending its performance, especially in the manner in which it was then done. These objections were chiefly based on the fear of wounding the peritoneum, and the danger of urinary infiltration and consequent sloughing and peritonitis. Under the methods then employed these dangers, especially the second, were scarcely exaggerated. There is always a possibility of wounding the peritoneum, but with the improved technique of to-day the *probability* is slight and the actual danger less. With regard to urinary infiltration this danger is greatly lessened, if not entirely avoided, by the use of the perineal drain. In very old men the tissues are lax, and infiltration of the diseased urine into these tissues, whose vitality is impaired, is attended with greater danger than with younger persons, who have

greater vitality. A generation ago, before the advent of the aseptic method, wounding of the peritoneum was considered to be attended with extreme danger; and, also, the danger of peritonitis arising from urine flowing out of the bladder and infiltrating the tissues was hardly overestimated. Even the means now employed for rendering the wound and urine aseptic are not sufficient if the urine is decomposed (as it is in most old men with prostatic enlargement and stone) to overcome the danger where the urine soaks into the paravesical tissue. This I know by actual experience, for with the utmost care, with frequent cleansing, and excellent arrangements for siphonage, infiltration has followed, with resulting peritonitis and death. One would think it possible to maintain the urine disinfected and innocuous, but it seems I have not been able to do so with the most active disinfectants which I have dared to use.

Drainage through the penis is also both inefficient and painful to the patient, because often the urine refuses to flow through the catheter, which is fastened in the penile urethra, and this portion of the urethra becomes much irritated by the removal and reintroduction of the catheter; and, besides this, it is difficult to keep the catheter in place. In aged men the enlarged prostate gives additional difficulty. Bearing these facts in mind when called to operate upon the cases herein detailed, it appeared to me that the only proper method to be employed was the one which I here describe:

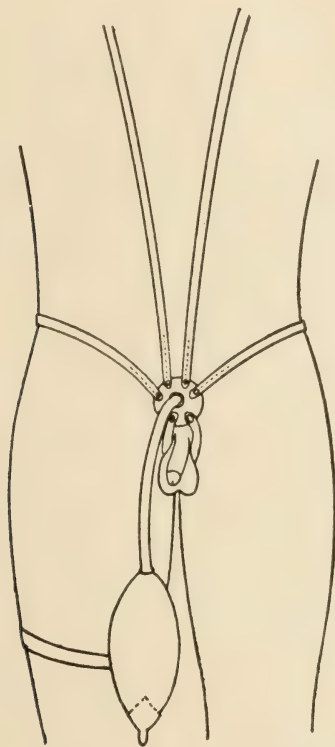
First. The bladder should be carefully and thoroughly washed with an aseptic solution, the normal salt solution being usually sufficient. Then the bladder is injected full, but not put on the stretch. The colpeurynter is introduced into the rectum and inflated with air. By the injection of the bladder with water and the inflation of the rectal colpeurynter with air the bladder is rolled upward and backward, carrying the fold of the peritoneum, and leaving a space on the anterior surface of the bladder which is not covered by peritoneum. There are exceptions to this rule, for sometimes the fold of peritoneum is reflected lower down on to the anterior wall of the bladder. Of course the possibility of this abnormality occurring in any case must be kept in mind. After injecting, a sound should be introduced into the bladder, or, better still,

the injection may be made through a silver catheter which has a stop-cock. The sound or catheter should have an unusually large curve and long beak, in order to sweep around the prostate. A broad strip of tape is tied around the penis to compress the urethra about the catheter, so that the solution will not escape by its side. The handle of the sound should be depressed by the assistant until the beak can be felt in the median line just above the symphysis pubes. This manipulation should be conducted with caution, and undue force avoided.

The incision is made in the median line and extends down over the pubis. After the recti muscles have been cut through or separated, the loose tissue in front of the bladder is carefully divided until nothing but the bladder intervenes between the end of the sound and the examining finger. The bladder is caught up with a strong curved tenaculum and incised and slit downward and forward—using the beak of the sound as a guide. The injected fluid escapes and the sound is removed. By means of the finger, the bladder is thoroughly explored. The forceps are introduced through the wound and the stones removed. As a rule the hæmorrhage amounts to little, but it is well to stop whatever flow of blood there may be.

The foregoing completes the first part of the operation. The next point is to secure efficient drainage, and the best way is through the perineum. This is really reviving an old method, and one which was resorted to by the older practitioners of suprapubic lithotomy—only, the technique and after-treatment differ materially. The patient is placed in the lithotomy position, the staff introduced, and a median perineal opening is made sufficiently large to introduce a good sized soft-rubber catheter through it into the bladder. Of course this catheter has been thoroughly sterilized, and is sewed into the wound by one or two stitches of silkworm-gut or other non-absorbent and non-absorbable material. A little gauze may be packed around the catheter if the wound is too large. This catheter may be left in place without changing for a week or ten days, if necessary, until granulation of the suprapubic wound has well progressed and there is no further danger of urinary infiltration. One may theorize as much as he pleases regarding the slight danger of urinary infiltration in suprapubic lithotomy

without perineal drainage, but an unfavorable personal experience in one or two cases is very convincing that the danger, especially in old men with loose tissues and diminished vitality, is a positive one, while with effectual perineal drainage the danger is very much lessened. The upper wound should not be closed with sutures but packed loosely with gauze, while at the same time siphonage is kept up as much as possible by means of a double catheter. All the catheters should be con-



needed to long tubes which lead down to bottles standing on the floor. It is needless to say that all these tubes, bottles, etc., should be sterilized two or three times daily by boiling. The dressing should be aseptic and as absorbent as possible, and should be changed frequently. The drains to the suprapubic wound may be held in place by means of straps of adhesive plaster which are fastened to the catheters by safety-pins which are struck into the sides of the catheter, but do not invade its lumen.

After granulation of the suprapubic wound is advanced, the arrangement which I show here is well adapted for holding the catheter in place, and has the advantage of not slipping about and displacing the catheter.

This apparatus, which is a modification of some already in use, was made for me by Mr. H. R. Kirsten, and has proved very satisfactory. It consists of a hard-rubber plate with a central opening. Through the opening passes a good-sized soft-rubber catheter, which fits tightly. The catheter is connected by tubing to a rubber receptacle which is fastened to the leg. The apparatus is held in place by shoulder-straps, a pelvic band, and perineal straps. These are made of soft rubber, with the exception of the upper part of the suspenders, so that they do not absorb the excretions and become foul.

The perineal tube is removed when the granulation of the upper wound is sufficiently progressed and the wound closed around the catheter enough to prevent leakage at the side. In very old men, where the probability of re-formation of calculus is great, the suprapubic drainage should be permanent, and the urine caught in a rubber bag which is attached to the patient's thigh as shown in the cut.

During convalescence the bladder should be washed out with the salt solution from two to four times daily, and afterwards at least once daily. Even this precaution may not prevent the formation of gravel in the bladder, because there are often deep sulci in which a nucleus may form which it is hard to dislodge, and in such cases a weak solution of nitric acid may be used to advantage.

CASE I.—Rev. J. P. L.; age 79; patient of Dr. John E. Wilson, of Bloomfield, N. J. Entered the Flower Hospital May 24, 1895. Only symptoms such as may be due to the presence of stone, but he suffered excruciating pain from this. Albumin present.

Operation as described above. Stone only the size of a hazelnut, but, being just at the neck of the bladder, acted as a constant irritant. After the operation everything progressed favorably, and the highest temperature was 99.2. On May 28th patient began to be very restless. This restlessness increased until he became mildly maniacal. He would not remain in bed and pulled off the bandages. In spite of this, however, he was able to be removed to his home on June 8th, where his

mental and bodily health were completely restored, and he lived for more than a year in comfort, dying finally of some acute trouble.

CASE II.—On March 14, 1897, I was called by Dr. C. C. Howard, of this city, to see Gen. J. C., aged 82 years.

He was suffering extreme agony—his symptoms being apparently due to urinary retention. I relieved him by means of a long prostatic catheter. The same procedure was employed the next night, but I did not detect the stone. Dr. Howard, after the urine had been drawn off, was removing the catheter, when a distinct click was felt, and the presence of stone confirmed. This patient was in an extremely nervous state, his heart was weak, and kidneys diseased.

Operation under nitrous oxide gas anæsthesia on March 18th. Method of procedure as before described, and two very large stones removed, one weighing 677 grains, the other 511 grains. The progress of convalescence was slow, and many complications threatened, but did not mature. Dr. Howard attended to the medical part of the case, and to his skillful homœopathic prescribing I attribute the avoidance of threatened danger. For instance, at one time it seemed as though dry gangrene was about to attack the scrotum and vicinity of the perineal wound. Secale stopped it at once.

He finally got about and went to his country place early in May, where he did well until the latter part of June, when he had a high temperature and some sloughing in the region of the suprapubic drain. This trouble soon passed off, and he resumed his daily walks and exercise. After his return to the city he walked and was fairly well until in January, 1898, when he again had pains in the bladder. On January 13th, under gas anæsthesia, I dilated the suprapubic opening and removed a number of small stones which had accumulated in a pocket behind the prostate. This gave relief, but the kidney disease was so far advanced that he gradually failed, and died from it the following month.

A CASE OF FRACTURE OF THE PENIS.—W. Miklaszewski observed a man of forty years who, in a moment of violent sexual excitement, bent his penis around his thigh. A violent, cracking sound occurred, and he felt a severe pain in his penis. Erection was followed by swelling and cyanosis. The following morning the organ was curved like a reversed S, and of violet color. On touch and during motion the penis was exquisitely painful in the right upper third of the dorsal surface. Micturition was unaffected and not painful. For ten days no change. Then the effusion of blood commenced to be absorbed. Incomplete but very painful erections followed. In fifteen days the organ appeared normal, but erections were painful.—*Przegląd Chirurgiczny* Tom. iv., Zeszty 1, 1898.

A CASE OF PROGRESSIVE MUSCULAR DYSTROPHY.

BY EDWIN H. VAN DEUSEN, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of Pennsylvania, Pittsburg, Sept., 1898.)

MRS. M. F. became my patient in 1881. I had known her since 1870. She was born in 1836. Her father died of pulmonary tuberculosis in 1851, at the age of forty-three. Her mother came of very hardy stock, and is still, at eighty-five years, a very vigorous woman, both mentally and physically. Mrs. M. F. in her youth was active and energetic, although always slender. She developed a cough when she was about eighteen years old, and her friends thought her consumptive. She was then engaged in school teaching. She afterward married, and four children were born to her, in 1860, 1862, 1863, 1868, respectively. The last child was born in February, and the muscular weakness was first noticed in the following November. From 1860 to 1868 she had been in much better health than in the years before. Her general health continued good until a few days before her death, in 1895, which was due to acute pneumonia. At my request she wrote for me, in 1885, the following statement:

"In November, 1868, I first noticed that I could not fully extend the second and third fingers of each hand. In January, 1870, the above difficulty having increased and extended to the other fingers, I called the attention of Dr. Dallam to it. Dr. Dallam happened to be attending another member of the family at the time. He from time to time gave *cannabis indica*, and ordered croton oil to be used on the muscles of the forearm as a counter-irritant. Then he recommended the use of a battery, which I did for six months. As the disease continued to increase, he recommended, in 1872, that I should see Dr. D. Hayes Agnew. Dr. Agnew pronounced it a case of reflex paralysis, caused, undoubtedly, by a fall down stairs which I had had eight years before. I slipped down the stairway, striking the end of my spine on every step. Tenderness persisted on pressure for a year or more. Dr. Agnew said the paralysis was caused by concussion. He recommended electricity, but

not to be applied by myself—only by a specialist. At his recommendation I went to Dr. M. Grier. For one year I was treated by him with electricity three times a week, the disease slowly but steadily increasing. In 1873 I consulted Dr. Agnew again, and for eight months I was under an internal treatment. The first half of that period I took Donovan's solution, and the other prescription contained strychnia.

"In the spring of 1874 I consulted Dr. Samuel D. Gross, and was under his treatment three or four months. His prescriptions were very similar to those of Dr. Agnew, strychnia appearing to be the principal drug. In addition, Dr. Gross recommended plunging my arms in hot water for a few minutes night and morning, and then have some one with a towel wrung out of cold water strike every part of the red surface with the fringe of the towel, snapping it in a quick, sharp manner. Then an ointment prepared from his prescription was to be rubbed in, and also to be rubbed down the spine. I do not remember what drug was in the ointment, but it was of such a nature that the Doctor told me to wear gloves at night for fear I might accidentally put my fingers to my eyes, and the result might be loss of sight. He also ordered lemonade (the juice of one lemon) drank immediately on rising in the morning. His treatment began to affect unfavorably my general health, and I ceased going to him. He, as well as Dr. Agnew and Dr. Grier, thought the paralysis the result of the fall of which I have spoken.

"In the summer of 1874 I saw Dr. Thomas, near Boston. He thought the disease resulted from the fall. . . . His opinion was that medicine would have no effect. . . . He thought the injury had spent itself, as I had not noticed any material change for some time. The latter opinion proved to be incorrect.

"In the winter of '75-'76 I went to Dr. Ellwood Wilson, on Sixteenth street. He thought I had not taken enough strychnia, so he gave me a prescription (strychnia and quinine the principal components), but after taking two of the pills (I was to take three a day) I had such roaring noises in my ears, nausea, sensation of being pulled backward at the back of my head, etc., that I went to him again, and he said to take but two a day. He also ordered my spine to be painted with iodine twice a day. The latter directions I followed for several weeks,

but never went again for medicine. . . . He told me that if I had not taken enough strychnia to cause involuntary jerking of the muscles of the limbs I had not taken sufficient.

"Shortly afterward I went to consult Dr. Wm. H. Pancoast (just to get his opinion in regard to the curability of the case). He thought I might be cured. He advised camphor liniment for a while, then to try dry cupping to the spine, and if these did not suffice to try something more severe, which I judged to be the red-hot iron, from what he had been telling me of a case of spinal trouble. . . . I faithfully followed his directions only as to the liniment and dry cupping.

"About 1877 or 1878, having had dull pain in both arms for about three months almost continuously, I consulted Dr. Francis Sims (homœopathist)—the first time I had ever tried anything but allopathic treatment for my trouble. In two or three weeks the pain had entirely left, and has never returned. This was the first time . . . that remedies ever showed the slightest effect. . . . I took copper in various forms, but with no benefit, . . . for about three years, until his death. He said it would be a triumph for homœopathy if it effected a cure. He acknowledged that it was a very peculiar case, that he had never seen or read of one just like it, and finally even began to doubt whether the disease was caused by the fall, as every remedy given had failed to make the slightest impression, and that perhaps they had all been working in the dark, and had failed to find the cause of the disease."

The foregoing statement throws no light on the progress of the disease and is of no value as a history of the case. It, however, is exceedingly interesting as the record of the opinions of an obscure condition expressed through the patient by some of the greatest physicians this country has known.

The progress of the case covered a long period—from November, or earlier, in 1868, to March, 1895. The first evidence of paralysis, as stated, was an inability to fully extend the second and third fingers of each hand. This was discovered while playing the piano. The loss of power very gradually increased, and extended to the other fingers, being always bilaterally symmetrical. In two years' time the extensor muscles of the forearms were so much affected as to occasion wrist-drop, and a consequent but fruitless search for lead as a cause of the dis-

ease. At about the same time there was a noticeable loss of power in the quadriceps extensor femoris muscles. One after another the various groups of muscles lost power, until in 1895 the voluntary muscles seemed to be all but powerless. Perhaps the biceps of the arms and the flexor muscles of the thigh were the least powerless. The patient was able to feed herself after the food was prepared. She used a pickle-fork about twelve inches long. In raising a cup to her lips she grasped the saucer with her right hand, and with her left hand under the right elbow and a forward inclination of the head, she was able to make the half-filled cup meet her lips.

She could write. She was a rapid and an excellent penman, and her writing in 1895 was not distinguishable from that of 1865. Writing seemed not to tire her. She did the correspondence of the household. She kept all accounts. She kept a tabulated list of all books she had read, and a synopsis of each. She probably wrote two hours every day. There was little else she could do. Reading, writing, talking and eating completed the circle of her daily experience. Her grasp of the pen was so weak that the slightest touch would knock it from her hand. Her mental faculties never showed the slightest sign of impairment. The co-ordination of her muscles was always perfect. Her muscular sense seemed to be even exaggerated. There never was any alteration of sensation. If raised to the upright position and allowed to become perfectly balanced she could stand. She could even progress, but not forward or backward. The use of the adductors and abductors of the thighs enabled her to move a few steps to the right or left.

When being carried in her chair she was always over-conscious of any tilting to the right or left, or forward or backward. The order in which the muscle groups became affected was about as follows:

The extensors of the hands, the extensors of the legs, the deltoids, the extensors of the forearms, the muscles which fix and elevate the scapula, the flexors of the hands, the flexors of the neck (sterno-cleido-mastoidei), the muscles of the abdomen, and last of all and least of all, the flexors of the forearm (biceps), the flexors of the legs, and the muscles which support the spinal column.

From the beginning to the end the progress of the motor

paralysis was slow but steady and constant. Twice there seemed to be an improvement. The wrist-drop, after persisting for a year or more, gradually disappeared, but only because the flexors of the hands, which had antagonized the extensors, had become weakened. The same thing occurred in the neck. There was a time when, if she inclined her head backward to look directly upward, she remained in that position until some one came to her assistance, unless the back of her chair was high enough to enable her, by slipping forward on the seat, to push her head upward with the back of the chair. This very uncomfortable condition of affairs passed away when the muscles of the back of the neck had become so weakened as to be unable to successfully resist the performance of the function of the anterior muscles.

Probably in the first ten years or less all the muscles had become affected, and subsequently there was a very gradual advance of a disease existing in every muscle of the organism.

A few years after the commencement of the disease the patient's general health had decidedly improved. She had gained in weight, probably twenty pounds. There were no disproportionate parts, but all the muscles, as well as the parts about joints, had increased in size. The shoulders had become more sloping, from a drooping of the scapulæ. She occasionally developed a cough from alterations of temperature during the night, since she was unable for the last ten years to change either her own position or that of the bedclothing. Her cough was hollow and seemed to require a great effort, and was accompanied by intense redness of the face and neck. This redness also appeared with every slight emotion, either of pleasure or annoyance. As the redness subsided it left the skin mottled purple, red and pink, gradually fading to the usual good healthy color. Any difficult exertion, such even as putting on her glasses, or reaching for her pen, if not at hand, would to a greater or less extent occasion the same phenomenon.

During the whole period of the disease she had very few symptoms other than those due to the loss of power. For several months, as mentioned, she had aching pains in both arms. For several years she had almost constantly a cracked condition of the skin and mucous membrane at the corners of the mouth. This was worse in cold weather. She took nitric

acid 6 for several months, and the symptoms disappeared and did not return.

She occasionally complained of indigestion at night, and as the discomfort was relieved by whiskey she developed the habit of taking it usually just before bedtime. For several years before her death she probably drank in this way from eight to ten quarts of whiskey a year.

At no time was there the slightest evidence of mental impairment, or even of alteration of her disposition. She submitted not resignedly but contentedly to her limitations.

It will be of interest to mention, as an addition to the patient's written statement, that during the period from 1885 until her death she saw in consultation two physicians eminent in diseases of the nervous system. One is affiliated with the Homœopathic School and the other with the Old School. The treatment of each was followed faithfully, and was equally unavailing. Each made a careful, painstaking examination. Each found sensation normal. Each found the reflexes wanting. Each found the quantitative electrical contractibility proportionate to the voluntary control. Each found entire absence of any affection of the sphincters of the bladder and rectum. Each was convinced that there had been no fibrillary twitchings. One elicited the reaction of degeneration. The other, two years before, had been unable to do so. Both recognized the progressive character of the paralysis. Both failed to find any evidence of heredity or the existence of the disease in other members of the family.

The opinions formed by the two men were diametrically opposite. One declared that there was no evidence of disease of the motor tracts in the cord, and the other made a definite diagnosis of poliomyelitis anterior chronica.

Dr. Jacoby, in the article "Diseases of the Muscles," in *Der-cum's Nervous Diseases*, by American authors (1895), writes upon the subject thus :

"Differentially, the affections (various types of progressive muscular dystrophy) must, above all, be separated from the spinal form of muscular atrophy. If we remember (1) that the latter rarely shows any heredity, (2) that the onset is usually late in life, after adult age has been reached, (3) that it usually commences in the small muscles of the hand, progresses to the

forearm, upper arm and body, affecting the lower extremities only very late, (4) that hypertrophy is never present and (5) fibrillation nearly always, and (6) that the atrophied muscles show the reaction of degeneration, then muscular and spinal atrophies will only rarely be confounded."

Of the six points mentioned as characteristic of the spinal form of atrophy, five could readily be applied to the case under consideration.

Dr. Dana, in his *Text-book of Nervous Diseases*, page 313, writes: "In the muscular dystrophies there is commonly (1) a history of heredity, (2) the disease begins in childhood or adolescence, (3) it attacks the lower limbs oftener, (4) it is slower in progress, (5) there are no fibrillary twitchings, and (6) the degeneration reaction does not occur."

These statements will serve to point out the difficulties in the way of a correct ante-mortem diagnosis of the case. In 1895 the patient developed a pneumonia which resulted fatally.

A very careful autopsy was made by Dr. Carl V. Vischer. The development of subcuticular fat was considerable, being more than an inch on both chest and abdomen.

The heart was normal in size, but in such an advanced state of fatty change that with very slight pressure the finger could be pushed through the walls at any point.

Both lungs were the seat of a pneumonia, more recent in one than in the other. Both apices contained contracted scars, the larger in the right lung.

The diaphragm and the bladder and intestinal walls were decidedly thinner than normal.

The muscles, when cut across, presented a startling appearance. Their size and form were retained, but there was no color of muscle. Macroscopically, the fatty metamorphosis seemed almost complete. Careful inspection was necessary to discover any muscle fibres. The change was least advanced in the anterior tibials, the muscles of the posterior aspect of the thigh and the biceps of the arms. The spinal cord was removed entire by eviscerating and chiselling off the bodies of the vertebræ. Macroscopically, it presented no deviation from the normal appearance. Microscopically, also, the sections of various parts of the cord were found to be normal, except that in the cervical region the vessel-walls presented evidence of moderate atheroma.

The median and sciatic nerves were examined and found normal. In the sections of the muscles "microscopically the myocin was everywhere degenerated, the degree of change being varied. The greater number of fibres were granular, the granules being here and there fused, forming droplets. Some fibres showed the longitudinal striations described by Erb, and this condition coexisted with the transverse markings. Numerous sarcolemma sheaths were observed which contained no muscular substance whatever, the myocin evidently having undergone complete destruction."*

No examination of the brain was made.

We have here a case in which the only departure from health is the slow, persistent, progressive, degenerate metamorphosis of all the muscles. Whether the primary disease was in the muscle or in the theoretically probably but practically undemonstrated trophic centres is indeterminate. It is even conceivable that the fault lay somewhere in the hæmatopoietic department of the economy, and that, consequently, the pabulum necessary for muscle nutrition was for years not supplied in the requisite quantity and quality. While the settlement of these questions would be of immense advantage, we are not permitted to await this event before commencing treatment.

In this case the patient received massage, electricity, light gymnastics, counter-irritation to the muscles, counter-irritation to the spine, application of heat and cold, and such drugs as strychnia, quinine, arsenic, iodide of potash, and mercury in large doses; and in smaller doses, lead, copper, nitrate of silver, etc. Nothing appeared to check in any degree the progress of the disease. It was like the rising of the tide.

Ante-mortem, the case was one of tremendous difficulty to both the diagnostician and the therapist. The autopsy has cleared all doubt concerning the diagnosis, and has presented a very strong hint as to treatment. If we will study our drugs from a pathological standpoint, and study this disease from a pathological standpoint, we will be astonished to find how close is the analogy between phosphorus effects and the

* The microscopic examination was made by Dr. J. R. Hunt and confirmed by Dr. C. W. Burr, and the case was reported by F. S. Pearce in the *University Magazine* for May, 1896. The importance of the case from a therapeutic standpoint is one among several reasons warranting a report from another source.

progressive muscular dystrophies. The necrotic and gastrointestinal effects (except the fatty degeneration of the gastrointestinal walls) are local and acute effects. The disintegration of the blood, and consequent hæmorrhages, are more or less acute effects of large doses. The chronic effects of phosphorus are, in the main, fatty metamorphosis of glands and striped and unstriped muscles. No premeditated proving would ever be carried to the extent of fatty degeneration, and all other reports must necessarily be of crude effects. Therefore we would not be likely to get from either phosphorus provings or poisonings a symptomatological picture of muscular dystrophy. However, if we need a text-book excuse for the prescription, we will find, upon reading phosphorus in any materia medica, a superabundance, and not a paucity, of corresponding symptoms.

A slowly progressive paralysis without wasting of the affected muscles, without sensory disturbance, without implication of the sphincters of the rectum or bladder, without fibrillary twitchings, and without exaggeration of the deep reflexes, is probably myopathic, and not myelopathic, in origin. In such a case phosphorus (not lower than the sixth decimal attenuation) used for months is a remedy well worth trying, in the hope of checking the further progress of the disease, and of even restoring the impaired function. Electricity, massage, active and passive movements, heat and cold would be valuable adjuvants.

GASTRIC DILATATION.

BY GEORGE B. HAGGART, M.D., ALLIANCE, OHIO.

(Read before the Homœopathic Medical Society of Eastern Ohio, Canton, October 19, 1898).

THE subject of my remarks to you to-day is "Gastric Dilatation." I mean to give special prominence to diet as a factor in its treatment and cure.

The care of cases of this disorder has been forced upon me of late, hence the forced study of its details, and I wish to remark that any indications for treatment given by me are more the results of practical experience than of knowledge gained from library sources.

Let us first learn what constitutes gastric dilatation, and in defining it we have only to differentiate between it and its allied disorder, gastric hypertrophy. Gastric dilatation means enlargement of the cavity of the stomach, while gastric hypertrophy refers to thickening of its walls. They are occasionally found together.

The normal stomach should hold three pints. It has been known to contain ninety pints, or, practically speaking, one-third barrel. Its diagnosis is easy. We can remember that in the normal undilated stomach the cardiac orifice lies opposite the junction of the seventh left costal cartilage with the sternum, while the pyloric orifice is opposite the juncture of the eighth costal cartilage with the sternum.

“Burkhart’s tender spots,” two ganglionic parts of the abdominal sympathetic situated on either side the spinal column at the posterior part of the abdominal cavity, are especially sensitive in this disorder.

Beside, the greater curvature of the stomach can be felt—especially easy if you have taken care to give a seidlitz powder to your patient preceding the examination; and, if you wish to preserve and compare the outlines gained by palpation and percussion, merely outline with a soft pencil the boundaries of the organ and ribs, and perhaps contiguous viscera, and transfer it to a strip of gauze or oiled paper placed over the skin outline. In this way you may make monthly comparative estimates of your treatment and correctly judge the results.

Another method of learning the location of the lower curvature is to listen with a stethoscope while the patient swallows small sips of water, dotting with pencil the lowest point at which you hear it fall when it reaches the stomach.

The causes of gastric dilatation are many. I shall give prominence to but two. Stenosis, usually the result of malignant disease at the pylorus, ulceration and consequent lessening of the pyloric diameter, and overeating, resulting in faulty digestion, fermentation, and ultimate paralysis and dilatation of the circular muscular fibers of the stomach.

It is commonly stated that “the Americans are a nation of starch-eating dyspeptics.” The Asiatics eat no meat, and yet dyspepsia in their numbers is rare. I think the reason is plain: the Asiatics eating many dishes of food—the Americans eating too much.

Twenty ounces of food, properly selected, will not only supply life for a single day but furnish everything the system will require to suit its environment and occupation. Practically, then, a cupful should constitute a single meal.

In cases of dilatation the result of malignancy, medicine offers considerable relief. The remedies whose simillimum are most frequently found are arsenicum alb., 3x-6x; conium mac., 3x; strych. phos., 6x; china off., 2x, and bryonia alb., 3x.

If operative procedure is determined upon there are two forms. The first, pyloric stretching, the results of which have been poor indeed, ending in the majority of cases in peritonitis; and the second, removal of the stomach in whole or part, the results of which are indifferent, though greatly lauded.

In dilatation of the stomach the result of overeating, with consequent fermentation, we must look at once to the digestion of starch. Starch in its digestion passes through four stages before assimilation occurs. On meeting the salivary secretion the starch changes to amylodextrin.

This is the degree of change to which twenty-minute cooked oatmeal, boiled potato, biscuit and "minute pudding" have attained when usually served. The next stage is that of erythrodextrin, and this is the degree of change in five-hour cooked oatmeal, baked potato, and a few ordinary foods. The third stage is that of achroödextrin, and this is represented in ordinary foods by crusts of bread, wafers, zweiback, browned rice, etc. From this third degree of changed starch maltose is formed, and assimilation follows.

Another cause of dilatation from fermentation is the food combination usually made, as, for example, the eating of milk and vegetables and fruit and vegetables, which are bad combinations, in place of grains and fruit and grains and milk, which are good ones.

A third reason of fermentation is the taking of foods too difficult to digest. Examples of animal food are pork, veal, goose, liver, sausage, cheese, oily fish, fried meat. Examples of vegetable food difficult of digestion are warm bread, pies, griddle-cakes, preserves and chocolate.

A fourth reason of fermentation is the composition of the ingesta. Sauerkraut is an example of an already fermenting food. Wine and cider, with the danger of animal parasites in

the vinegar; eels in the latter. Beer, which is now only a quassia infusion charged with carbonic acid gas and flavored by hops. Other examples are wild game, honey, candy, coffee, beans and ordinary mushes.

And now what can we do for these poor mortals? They come to you lean and weak. They are mentally the picture of despair. Their fondest hopes have fled. Medicine has failed generally and in special form. They ask not for scientific suggestions but for practical relief. They tell you they eat enough. What will you advise?

I wish to specially call to your attention the dry diet, or, as sometimes called, the "aseptic diet." On the onset you will ask me why. One especial reason is that fluids, as usually advised in the form of soups, broths, expressed juices, etc., lay too long in the stomach, and peristalsis is not stimulated by them. Another reason is there is generally, as I have before mentioned, a lack of mastication when fluids are taken, and with the usually prepared mushes and the starch, fermentation follows. We must remember the American is a man of haste; that his noon-day message is, "Gone to dinner—back in five minutes;" and that he has almost gotten to the deplorable state of the tramp who requested the kind country lady to "give him his pie in capsules, because he was actually too tired to chew." A third reason for a dry dietary is the use of tobacco, with its consequent waste of saliva and resultant lack of assimilation of starch, breeding a cadaverous humanity, and all the digestive and nervous ailments. But by far the greatest reason for the dry dietary is that it overcomes acidity; leaves the man the necessary forty minutes to digest starch before the acidity of meat digestion begins; and in this connection I wish to mention three acids that are the foes of starch digestion. Hydrochloric acid is one, the accompaniment of the digestion of meat; and what starch has not been acted on by salivary ferment when this occurs must await its chance of intestinal digestion at the hand of the pancreas.

Another acid is acetic, usually taken, under the hope that it will facilitate meat digestion, in the form of vinegar. Now, 1 per cent. of vinegar will overcome the digestion of starch; in other words, one teaspoonful of strong cider vinegar will overcome the digestion of a full starchy meal.

Oxalic acid, as gotten in rhubarb, is a foe to digestion of starch; and where, I ask, is the food-value of oxalic acid in rhubarb combined with a starchy crust, as in the common rhubarb pie?

The perfectly dry dietary consists of hard-boiled eggs (cooked one to two hours), crumbled; crusts, toast dry; popcorn; nuts, as almonds and peanuts; sliced, well-baked bread; and the prepared foods, granose and ambrosia. Many patients cannot, and necessarily need not, take the perfectly dry dietary, but may modify it by adding or alternating with parts of it the following: Whipped cream, plain or flavored; cottage cheese; scorched rice; boiled, strained peas; whipped white of egg, combined with one-half ounce best cocoa wine.

In many cases of not severely dilated stomach I give the following well-cooked preparations: Oatmeal (cooked four to five hours), corn-bread, hominy, cooked milk, custard, and milk fresh from the cow.

The general directions are very important. It is a mistake, I think, to not give fluids; but they should be given only as diluents, at night, two to four ounces, sipped slowly. Seltzer or carbonated water is especially good. Rectal injections retained, and of small amount, will suffice when none can be tolerated on stomach.

For the pernicious constipation usually present, use an olive oil or cocoa butter rub, or the usual "cannon-ball massage" given in sanitariums, flaxseed rectal injections, or plain water.

Meals should be given often, of small quantity, and taken in bed or during perfect physical rest, and should be eaten slowly.

In regard to exercise, it is especially important to the well-nourished body—it increases the diaphragmatic activity, assists the purification of the blood and increases the appetite.

The remedies are usually to be chosen to fit the individual simillimum. Carbo veg. alone is important to prevent fermentation. Calcarea carbonate in high attenuation is especially often indicated. I regard it as suggestive that a disease caused principally by an incorrect dietary and bodily habits requires the opposite to cure it, and hence have given especial thought to the food, and have generally been rewarded in so doing by better results than by any medicine.

COMPLICATED TWIN LABOR.

BY D. C. KLINE, M.D., READING, PA.

(Read before the Homœopathic Medical Society, State of Pennsylvania, Pittsburg, Sept., 1898.)

CAZEAUX claims that twin pregnancies occur once in from seventy to eighty confinements. Fortunately it is, at least, that they are comparatively rare, for many a fond parent would be inclined to think the Lord was blessing him unduly well in giving them more than one babe at a time.

It has been my privilege to be present at a number of twin labors, but in comparatively few instances have both babes been well developed or thriven. In one case where the mother suffered from albuminuria, with convulsions, several hours after delivery, the one babe died within an hour, and the other was a miserably-rickety frail child, but is still living, now probably six years of age. I very well recall a case which I attended some few years ago, being called at 2 A.M. to one of our suburbs, the husband informing me that his wife had been in labor for several hours and needed help badly. On reaching the patient I found the cervix dilated, membranes ruptured, amniotic fluid had already escaped, a cord prolapsed, and a twin pregnancy existing. One vertex was attempting to present, but was intercepted by the locking or wedging of the head of the second child upon the shoulders of the first; they were wedged firmly down into the pelvis, and the uterine contractions held them there. After considerable persistent effort during intervals of pain, I succeeded in extricating them by introducing my hand, lifting the second child up and allowing the vertex of first child to descend and engage—first child living, second dead, and no tears were shed. I was convinced that the grandmother had made an attempt to effect delivery, but, after failing, sent for me.

But the case of twin labor I wish especially to relate was one to which my friend, Dr. F. W. Seidel, summoned me for consultation in October, 1896.

We found Mrs. K., 34 years old, in her ninth confinement, including two miscarriages, thus making her the mother of ten

children. We found a pale anæmic woman, almost pulseless, apparently in a state of collapse from hæmorrhage. The doctor informed me that he had a case of placenta prævia, with excessive hæmorrhage, no pains or uterine contractions, a cord of funis prolapsed, and, he thought, a case of twins. I hastily, but thoroughly, washed and disinfected my hands and arms, and by the doctor's request proceeded to an examination. I found the cervix partially dilated, a funis protruding, and blood flowing as from a hydrant. Proceeding further, I came in contact with a placenta which had been attached to the entire circumference of the cervix, but was now partially detached from the left side of the uterus, thus causing the excessive hæmorrhage, and allowing the escape of amniotic fluid and descent of the funis. The vertex was presenting, but there was absolutely an entire absence of labor-pains, although ergot had been administered by mouth and subcutaneous injection. With the patient on an obstetrical pad, and brought near the edge of the bed, I carefully and promptly loosened the after-birth (which, however, in this instance, might be denominated a front-birth instead of after-birth), and delivered it, tied and severed the cord. During this time Dr. Seidel made compression over the abdomen to, if possible, aid contractions, or at least serve as a *vis a tergo*.

No signs of labor proceeding, however, and considering the patient's depleted and exhausted condition, we deemed it wise to empty the uterus, and therefore immediately applied the forceps to the vertex and delivered the first child. By the time this was accomplished, the abdominal compression being continued, I was enabled to reach the breech of the second child, and, with no special difficulty, succeeded in delivering it and the second placenta. While engaged in the delivery of the babes the fountain syringe had been filled with boiled water carbolized at a temperature of 115°, and with my dull douche curette washed and curetted the uterus, first, in order to remove any *débris* or remnants of after-birth, of which there was considerable, at the point of implantation of first placenta; and, secondly, to gain the effect of the hot water upon the uterus in order, if possible, to aid contraction. While using the hot water we called for a cup of vinegar, heated and diluted with double the quantity of hot water, which I slowly

threw into the womb to further aid the contractions and revive the patient. We then washed the patient, applied a wet bi-chloride dressing to the vulva, removed the blood-soaked bedding and placed her dry and comfortable, administered some stimulant, and left her cheerful, but weak or well-nigh depleted. She was kept perfectly quiet and at rest, not allowed to raise her head for a few days, and made a good and uneventful recovery. Both babes were, of course, dead, having that pale, waxy appearance, as though entirely free of blood. I have since learned that the mother is subject to convulsive seizures about four times a year, these occurring since her first confinement. There are five strong, healthy children living. A rather singular feature is that the husband spent the greater part of the day in the bath-room, suffering a severe attack of diarrhœa and vomiting; this he does each time the wife is confined.

This we regarded as a mixed case of labor: 1, excessive hæmorrhage; 2, prolapsed cord; 3, placenta prævia; 4, twin labor; 5, application of forceps; 6, breech presentation; 7, entire absence of pains throughout. The only redeeming feature in the case, seemingly, was a spacious vagina.

THE PHARMACOPŒIA AGAIN.

BY T. H. CARMICHAEL, M.D., PHILADELPHIA.

THE paper of Dr. J. W. Clapp on the "Comparative Strength of Tinctures," together with the editorial "Pharmacopœia" in the last *HAHNEMANNIAN*, are important contributions to the literature of this subject.

The new work is the expression of the will of the American Institute of Homœopathy that the preparations of the New School should be made according to a uniform standard of recognized scientific value. The work, therefore, is based upon the recognized laws of pharmacy, which are simply those of physics and chemistry. Adverse criticism of it, for the exclusion of preparations that are unscientific from these standpoints, is therefore gratuitous. For illustration, on p. 43 the *Pharma-*

copœia treats of the limit of divisibility of matter in the making of triturations, and states that "By our mechanical methods particles reduced to $\frac{1}{2000}$ to $\frac{1}{3000}$ of a millimetre cannot be reduced any further by any method so far devised"—that these particles are equal in size to those obtained by precipitation—and "that these remarks have reference to the long-established custom of attempting to make dilutions from the 3d centesimal or 6th decimal trituration, as this does not produce perfect solubility of ordinarily insoluble substances in the sense hitherto erroneously accepted."

Against this has been arrayed Hahnemann's statement, "In order to convert the potent trituration into the liquid state and still further develop its power, we avail ourselves of the experience, hitherto unknown to chemistry, that all medicinal substances triturated to the third are soluble in water and alcohol."

Now, with all deference to Hahnemann, and with all the successes that have followed the use of 30ths and higher potencies by his illustrious successors (and we are of the opinion that their present use would be more efficacious than the polypharmacy that prevails in some quarters), yet "the experience hitherto unknown to chemistry" is still unknown to that science.

Neither do certain well authenticated experiments seemingly of a biological character, such as the destruction of several minute forms of life by the mere suspension of insoluble metals for a brief time in the water of the vessel in which they were contained, prove that any physical or chemical change took place because by no method thus far known to science can any change be detected in the insoluble substances so immersed.

It is evident that the fact that Hughes prefers for his own use the higher dilutions (12th to 30th) of *calcarea* for relieving the pain attending the passage of biliary calculi (see Hughes' *Pharmacodynamics*, pp. 345-46), or a hundred other instances of a similar kind, do not prove "the experience, hitherto unknown to chemistry," that *calcarea* triturated to the 6x thereby acquires a property of solubility in water or alcohol that admits of its further subdivision up to the 30th and higher.

It is manifestly unfair to assert that the *Pharmacopœia* or its compilers have repudiated "the work of homœopathic physicians in the past."

A pharmacopœia simply contains directions for the preparation of medicines according to the recognized scientific principles that underlie the art of pharmacy.

Therapeutic successes have been made with all sorts of agents, many of which can have no place in such a work.

Indeed, Hahnemann seems to indicate a belief not so much in the 30th as a solution of finely-divided matter from the 3d trituration of some insoluble metal as in some new force. He says: "Modern wiseacres have even sneered at the 30th potency, and would only use the lower, less developed and more massive preparations in larger doses, whereby they have been, however, unable to effect all that our art can accomplish. If, however, every potency is dynamized with the same number of succussive strokes, we obtain even in the 50th potency medicines of the most penetrating efficacy, so that every minute pellet moistened with it, after being dissolved in a quantity of water, can and must be taken in small parts if we do not wish to produce too violent an action with sensitive patients, while we must remember that such a preparation contains almost all the properties latent in the drug now fully developed, and these can only then come into full activity."*

Now, granting that this be true, it does not prove that insoluble drugs when triturated to the 3d or 6x become soluble in water or alcohol, or that the force produced in 30th potencies is a chemical one "hitherto unknown to that science."

The *Pharmacopœia* is therefore more exact in placing such preparations in the unofficial list, for this is practically what the statement on p. 41 amounts to: "While we are bound to ignore nothing which modern science has revealed, and while we are desirous of keeping abreast of it, it is not incumbent upon us as pharmacists to limit by any arbitrary rule the degree of dilution or trituration which might be desired." In other words, 30ths and 200ths will continue to be made from 6x triturations as before, and no pharmacist using the *Pharmacopœia of the American Institute of Homœopathy* would "be justified in supplying all dilutions above the 12th from his alcohol bottle, or the triturations higher than the 12th from his powdered sugar of milk stock," unless he were a dishonest man, in which

* *Chronic Diseases*, Preface to Fifth Volume.

case his ethics were hardly derived from the new pharmacopœia.

Since 1850 the *United States Pharmacopœia* has been revised every tenth year, and in all probability the *Pharmacopœia of the American Institute of Homœopathy* will receive similar revision—this first edition may be revised in five years.

Whenever this is attempted, we would suggest inserting at the foot of p. 43, in place of the paragraph beginning "These remarks have reference to the long-established custom of attempting to make dilutions from the 3d centesimal or 6th decimal trituration, as this does not produce perfect solubility of ordinarily insoluble substances in the sense hitherto erroneously accepted" (which is only an irritating reiteration of what has already been stated), the following plain statement: "Liquid preparations called potencies, first recommended by Hahnemann, have been used with great success by many physicians. They are prepared from 6x triturations (irrespective of the insoluble nature of the substance triturated) by mixing 1 grain in 50 minims of distilled water and thoroughly succussed, and this, mixed with 50 minims of alcohol, gives the 8x potency. One minim of 8x potency to 9 minims of dilute alcohol gives the 9x potency, and 1 minim of 9x to 9 minims of alcohol gives the 10x potency, and so on to the 60x, or higher; or they may be prepared on the centesimal scale, in which case 1 grain of the 3d trituration (6th of the decimal scale) is mixed with 50 minims of distilled water, and this with 50 minims of alcohol, which gives the 4th potency (8x).

"One minim of the 4th to 99 minims of alcohol gives the 5th potency, and so on to the 30th or higher. Every potency is to receive thorough succussion.

"Triturations have also been made up to the 60x, but these have not been so popular as the potencies."

The addition of the above, without note or comment, could not impair the scientific value of the work, which should be hailed as a unifying force among the profession.

Rarely has a work of this character appeared that gives so little ground for adverse criticism, while the immense advantage that it secures in being the creation of the American Institute should speedily cause its adoption by all our pharmacists.

PRIMARY CARCINOMA OF THE OVARY.

BY THEODORE J. GRAMM, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society, State of Penna., Pittsburg, Sep., 1898).

My interest in the subject of primary carcinoma of the ovary received its incentive from a case which recently came to my notice. The woman, a patient of Dr. H. A. Lacy, was 52 years of age, rather large, and had always been accustomed to hard work. She has had one child, twenty-three years ago, and no abortions. Her health was good until January 1, 1897, when she became ill and noticed a gradual enlargement of the abdomen, and at the same time had pains, rheumatic in character, in several joints. Dr. Lacy first visited her on May 13th, at which time he found the abdomen distended by a large hard tumor, but slightly movable. It was said that the bowels had not been moved for two weeks. She was emaciated, and the lower limbs were somewhat œdematous. After the bowels had been moved by means of rectal enemata and cathartics, the patient improved somewhat. When I saw the patient with Dr. Lacy she was confined to bed. The face was pale and of a somewhat yellowish color. The liver was not materially enlarged, and there was no albumin in the urine. The vaginal secretion was apparently normal, and the cervix was in the condition usual to this period of life. In the vaginal vault the growth was felt, and in one place it was somewhat nodular. The fundus uteri was fixed in the right anterior part of the pelvis.

Although the case did not seem very hopeful, it was determined to give her the benefit of an abdominal operation, and for that purpose she was removed to the West Jersey Homœopathic Hospital for Women on June 8, 1897, where I operated on her June 12th, with the kind assistance of Drs. Geo. D. Woodward, E. M. Howard, and Charles Becker. On reaching the peritoneal cavity a large tumor was met, which was firmly imbedded in the pelvis, and fixed the uterus anterior to itself. The right Fallopian tube entered the growth by a cleft in its substance. The left ovary was found much smaller, globular in

shape, and not nearly so adherent. The right ovarian tumor was enucleated from the pelvis with some difficulty, and the left one was tied off. A curious condition was found in the appendix vermiformis. The organ itself appeared to be nor-

FIG. 1.



Anterior Surface of Primary Carcinoma of the Right Ovary, 5 x 7 inches in size.

mal in size and shape, but on the end of its free extremity there was a whitish nodule of hard consistency, and which did not communicate with the lumen of the appendix. Because of the condition found, the appendix was removed.

The larger right cancerous ovary accurately presented a cast of the inner part of the true pelvis, and posteriorly had the curve of the sacrum. The accompanying photograph gives its anterior view. The entire surface was nodular, and there were numerous adhesions. To touch, there was a fleshy feel, although not nearly so hard as a fibromyoma. This tumor

FIG. 2.



Primary Carcinoma of the Left Ovary, 3 inches in diameter.

was about five by seven inches in size. On section it was of brain-like consistency, and through it ran a meshwork of connective tissue. The smaller tumor, representing the left ovary, was globular in form, and nodulated. There were but few adhesions on its surface. The mesosalpinx, apparently free from disease, stretched over one side of the growth, while the tube was elongated, somewhat thickened, the fimbriated extremity

closed, and the lumen distended by a clear fluid. This fluid was liberated from the tube while handling it, and, after lying for a short time in the hardening fluid, obtained the shriveled appearance seen in the photograph. The cut surface of this tumor was the same as the one above described. The growth measured about three inches in diameter. Quite numerous microscopic sections were made in my laboratory of many parts of these tumors, and medullary carcinoma everywhere found. The nodule on the end of the appendix, however, had a different structure in that it contained a much larger amount of fibrous stroma, but there were the usual nests of atypically arranged epithelial cells. The lumen of the appendix was free from disease, but in the mesoappendix were found three nests of cancer cells. The lining of the Fallopian tubes was free from cancer, but in one place in the walls of the tube there was a cancer nest. This lay much nearer the peritoneal covering than to the inner surface of the tube. The dentritic processes within the tubes were fewer in number than are found in younger women, and were also much thicker.

As a result of the operation the patient was much improved in her general condition, no symptoms of obstruction of the bowels existed, the œdema disappeared, and she was relieved from the pains in the limbs. Her improved condition, unfortunately, did not long continue, for in about six weeks Dr. Lacy thought he could detect an increased resistance in the lower part of the abdomen. Somewhat later the pains in the limbs returned, and the patient was confined to her bed. She died on November 10, 1897.

On November 11th the autopsy was held. The line of union of the abdominal incision was firm. Immediately beneath, on the peritoneal surface, there were nodules of carcinomatous infiltration. These did not exist at the time of the operation. The line of suture of the abdominal walls was excised entire, in order to be able to examine the tracts of the buried silver wire which had been used at the operation. The upper part of the abdominal cavity seemed free from cancer, though the liver was somewhat enlarged. The pelvis was, of course, filled with cancerous masses. The uterus, which was rather small, was easily separated from the cancerous growths, and was removed from the body for more careful examination. The vagina and rectum were normal.

On examining the uterus, its peritoneal covering was, of course, affected by the cancerous process which surrounded it, and on making an incision entirely through the body its tissues were seen to be involved; but the endometrium was singularly devoid of any appearance of cancer, and there was no ichorous discharge or other evidences of malignant degeneration. I regard this as a peculiarly interesting fact, and one which seemed to confirm my opinion that we had to deal with a case of primary carcinoma of the ovaries, and not one starting from the uterus. This belief was verified by microscopic examination of the uterine walls, the endometrium being free from cancer. The suture tract of the buried silver wire placed in the aponeurosis at the operation was examined in cross-section. Although at the time of the operation there was no evidence of carcinoma of the peritoneum near the line of incision, and although, when removed, the scar seemed to be healthy, yet the microscope showed that the tract of the silver wire was filled with cancer cells.

The interest of this case centres in the fact that it is one in which the carcinoma began primarily in the ovaries, from which it was disseminated to other organs. This is verified by the microscopic examination which showed that the endometrium and the lining of the Fallopian tubes were free, although their walls showed a late involvement, doubtless by means of their lymphatic communication with the ovaries. This also explains the absence of metrostaxis and of purulent or other discharges from the uterus, as would have been the case had the process started in the uterus. Infection through the channels as in the above case has often been observed, though Reichel believes that cancer germs growing in the ovary reach the uterus after the manner of the impregnated ovum and there develop; and Gebhard* has reported an instance where a papillary growth was probably thus carried to the cervix, and there developed teat-like excrescences in the portio vaginalis, leaving the uterine cavity free.

In addition to primary carcinoma, cancerous manifestations are found in the ovary quite commonly as the result of malignant degeneration of papillary cysts. Of this form there are

* *Cent. f. Gyn.*, 1891, 576.

many cases on record. This is possibly the most frequent form in which cancer is here found. An interesting association is that of carcinoma simultaneously appearing in a dermoid cyst, of which Krukenberg* has collected eight cases. Carcinomatous degeneration of a dermoid cyst is much more frequently found.† Cancer affecting the ovaries and the uterus at the same time has been studied by Littauer,‡ who reports fourteen cases of this form in which the tubes were not involved. Sanger§ has met with a cancer which affected the ovary one year after the extirpation of a cancerous uterus, and the interesting point is that there was no recurrence at the vaginal scar, and in the abdominal cavity there were no other metastases to be found.

The reiterated statement that carcinoma of the ovary is rare, and usually a secondary manifestation of the disease arising in some other organ, led me to make an examination of the literature of the subject, with the result that more or less complete records of over a hundred cases have rewarded my search. These, arranged in tabular form, are most interesting, but lack of space precludes their publication at this time. In several respects there has been some modification of opinion since Cohn|| did his pioneer work, with reference to the subject of malignant diseases of the ovary, by collecting 100 cases from the extensive material offered at the clinic of Prof. Schroder. Freund also¶ has made a valuable contribution to the subject. Another similar collection of cases is reported by Leopold.** Lerch†† has written a very readable article, in which he exemplifies the various phases of carcinoma as it affects the ovary by a number of cases which he recites. From these and other articles we may obtain a very clear clinical picture of carcinoma, while the genesis of malignant new formations as they occur in the ovary is ably set forth by Nagel,‡‡ and in the extensive array of articles to which he refers.

The frequency with which cancer affects the ovary can only be approximated. The supposed rarity of the primary form

* *Arch. f. Gyn.*, xxx., 241.

† See Martin, *Cent. f. Gyn.*, 1889, 185; and Thumin, *Arch. f. Gyn.*, liii., 547.

‡ *Cent. f. Gyn.*, 1891, 68.

§ *Cent. f. Gyn.*, 1890, 557.

|| *Zeitscher. f. Geb. u. Gyn.*, xii.

¶ *Zeitschr. f. Geb. u. Gyn.*, xvii., 140.

** *Deutsch. Med. Wochenschr.*, January 27, 1887.

†† *Arch. Gyn.*, xxxiv., 944.

‡‡ *Arch. f. Gyn.*, xxxiii., heft 1.

was doubtless due to the fact that if the conditions in the pelvis be not seen early, the extensive adhesions which so rapidly form completely mask the original starting-point of the process. The more frequent performance of early celiotomy and the more careful examinations of specimens have shown that the disease is more frequent than was supposed, and the entire subject was again opened by Cohn in publishing a series of 600 cases of ovarian tumors which occurred in the service of Schroder, of which there were 100 cases of malignant disease. Freund found 18.8 per cent. of malignant cases among 100 tumors; and in 116 cases of ovariectomy Leopold found 26 malignant, = 22.4 per cent. But in regard to the frequency of cancer originating *primarily* in the ovary, we may take the cases of Cohn, 100 in number, and of these there were 12 cases of primary cancer, including one of adenoma malignum. Kratzenstein* has also observed 100 cases of malignant disease, operated by Olshausen, of which there were 18 cases of primary ovarian cancer. Leopold found 11 primary carcinomas among his 26 malignant cases.

The age of the patients merits a word of attention. We usually look for malignant manifestations of disease in the latter half of life, and yet in the cases which I have collected there are some noteworthy exceptions; so that it may be said that at the time of the menopause and at puberty carcinoma tends to affect the ovaries. Pfannenstiël says:† “Contrary to cancer of other organs, the fact first pointed out by Olshausen is to be emphasized, that cancer of the ovary frequently arises at a very early age, even during childhood, and indeed especially in the medullary form.” In the series published by Lerch there is a case in a woman aged thirty-five years, and in another of thirty years. Gaiser‡ treated a woman of twenty-nine years who had no complaints from the tumor until she was about to be delivered. Odebrecht§ records a case in a twenty-seven-year-old woman. In Freund’s published series appears the record of a woman of twenty-five years. Vineberg|| reports a twenty-one-year-old case who had been affected with metrorrhagia since puberty at the age of seventeen, and had always had an en-

* *Zeitschr. f. Geb. u. Gyn.*, xxxvi., 61.

† *Handbuch der Gynäkologie*, Bd. iii., heft 1.

‡ *Cent. f. Gyn.*, 1888, 122.

§ *Cent. f. Gyn.*, 1897, 974.

|| *N. Y. Jr., Gyn.*, 1894, 699.

larged abdomen. In a series published by Kratzenstien* there is the record of a girl of nineteen years, and of another aged sixteen. Pfannenstiel mentions a fourteen-year-old girl whose case Fritsch has reported. In addition to these, Olshausen† mentions having seen cases in patients aged twenty-six, twenty-three, twenty-one, nineteen, twelve, eleven and eight years. The larger number of cases, of course, occur in those who have reached the later years of life. It has been pointed out that a peculiar malignancy and rapidity of growth attend those cases in which the carcinoma develops in young women.

The question of operation is one concerning which opinions have changed somewhat of late. Formerly, the diagnosis of cancer being moderately assured, operation was refrained from. The first fourteen cases of the twenty-two reported by Lerch were most likely seen during the time when this opinion prevailed, for when this condition was suspected the patients were retained but a short time in the hospital, and then discharged to be treated in the out-patient department. From his fifteenth case on, ovariectomy was attempted if there was any hope of removal, or an exploratory celiotomy was at least done, and the actual conditions noted. As a consequence, life was prolonged for periods up to a year and longer. The results have been better than this in certain cases. The fourteen-year-old girl of Fritsch was examined eight years after by Pfannenstiel and found to be well. Fritsch had three other cases in which there was freedom from disease of at least seven or eight years. Another case was well four and a half years after abdominal total extirpation for bilateral papillary ovarian carcinoma and simultaneous uterine carcinoma and myoma. Freund has always advocated the operation. He advises to operate all cases, even those which cannot be operated completely, in order to at least palliate. In his article he has reported a series of fifteen cases in which life was prolonged from nine to sixteen months, and in some of them the disease was surely far advanced. He also calls attention to the fact that those patients having far advanced disease bore operation well; and, also, "the former fear of septic inflammation after operating ovarian cancer is shown to be unfounded." He advocates operating

* *Zeitschr. f. Geb. u. Gyn.*, xxxvi., 61.

† *Diseases of the Ovaries.*

even advanced cases, because the operation brings about a most remarkable improvement in their general condition, since interference with the performance of vital functions is abolished for a time ; and, while recurrence takes place ultimately, yet the death of the sufferer is less painful and altogether less horrible than if we simply look on, after the diagnosis is made, and allow the disease to take its dreadful course. Cohn believes that we should no longer ask whether we shall operate these cases or quietly look on while the patient hastens to her death, but rather we should endeavor to determine which cases shall we or dare we operate, and when shall we operate. Also, in how far do we run a risk by waiting, knowing, as we do, that a tumor benign in the beginning has a great tendency to take on malignant degeneration, as has been shown in many of the cases which are manifestly cases of carcinomatous or sarcomatous degeneration of previously benign tumors. Early operation is therefore strenuously advocated. Olshausen admits that treatment offers very little chance of permanent results, but advises not to hesitate to extirpate an ovarian cancer, if metastases are not present. Inasmuch as an entirely certain diagnosis of cancer is rarely possible unless metastases upon the peritonæum are demonstrable, we should proceed to celiotomy after the mere diagnosis of ovarian tumor, and after the incision has been made the tumor should not be left behind if it appears susceptible of complete extirpation. The question of extirpation assumes a different aspect when metastases are recognizable. If they are few, and situated in favorable localities, we should not fail to remove them, especially as their histological character is not always assured at the operation. He recited two cases in which metastases were present and were removed, and the patients lived one and two and a half years.

Regarding metastases, Freund has pointed out that while cancer spreads by continuity of tissue, and the small-celled infiltration rendering the tissue soft and succulent, the disease is carried to other places by means of the blood and lymph vessels ; but, in addition to that, small portions of the original tumor may be separated by movements of the body and of the bowels and during the course of an examination, and these portions often fall into the lowest part of the abdominal cavity, into the pouch of Douglas, and into the excavatio vesico-uteri-

num, and are rather to be called implantations. These differ from the other metastases in that, while they are firmly adherent to their site by connective tissue, yet they have a greatly diminished blood supply, and he has rarely found any vessels of material size. They may be readily removed.

Diagnosis.—The results of operation until now, while much better than heretofore believed, leave very much to be desired. As has been shown, the operation offers more for the patient than was supposed, relieving her, as it does, of many of the interferences with the performance of vital functions and making her death less horrible. Yet, in order to improve the advantages offered by any operative interference, it is absolutely essential that an early diagnosis be made. The tendency of the times is to operate ovarian tumors much earlier than formerly. The study of carcinoma, sarcoma and malignant degenerations of ovarian cysts should act as a pronounced incentive for urging early operation. The question of the diagnosis of a malignant tumor of the ovary is one, therefore, to which our attention may be directed with profit. One of the earliest symptoms of carcinoma of the ovary seems to be cessation of the *menses*. In the later stages of the disease the menses are always absent. Some of the cases affected at the time of puberty had menorrhagia and metrorrhagia. *Ascites* has been a very constant symptom observed in all the recorded cases; and during the time when ovarian cysts were punctured more frequently than at the present time, it was soon found that this collection of fluid rapidly returned after puncture. *Ascites* associated with a movable tumor of small size is a very suspicious sign. It has been pointed out by Frank* and others that ascites appearing in a woman, aside from diseases of the liver, kidneys and heart, can only occur from peritoneal tuberculosis, movable solid tumor of the ovary or uterus, and from malignant disease of the ovary.

Edema of the lower extremities, while not appearing quite as early as ascites, must yet be called an early symptom, and one which Olshausen regards as a certain diagnostic sign. In the later stages it is always present, and is then due to compression of the veins from the many adhesions which form so

* *Am. Pract. and News*, July 10, 1897.

early, and from infiltration of the lymph glands. Carcinoma of the ovary is often *bilateral*, as has been frequently noted in the reported cases. The tumors are at first pedicled, and hence movable. Soon, however, *dense adhesions* form with all the neighboring organs, and this has been one of the most constant observations. At this time, if not before, the growing tumor will be felt to be *nodular*. While the tumors are yet small they retain the shape of the ovary, or they are *spherical* in outline. The disease often begins insidiously, and not until ascites becomes marked does the patient think of consulting the physician. In some instances, however, the cancerous disease begins acutely with inflammatory symptoms. Olshausen has recorded such a case, in which the patient was attacked by severe peritonitis, after which the abdomen remained enlarged, and she suffered from pain and ascites. The patient died within one year.

After the symptoms referred to have existed for some short time rapid emaciation supervenes. Anæmia and cachexia soon become well marked, and the end is not far off. *Pain* is by no means a constant symptom of carcinoma of the ovary. In many of the cases pain was entirely absent, while in others it was lancinating or burning in character. The rapid course of carcinoma in general is greatly augmented when the disease affects the ovary. It has been frequently recorded that only a few months have elapsed from the appearance of the first symptoms until the death of the patient; and in some instances the patient only lived a few weeks after considering herself sufficiently ill to consult a physician.

The diagnosis of carcinomatous degeneration of a pre-existing tumor, Cohn has pointed out, may be based on sudden rapid increase in the size of the growth, the appearance of ascites, which was not present until then, œdema of the lower extremities, aggravation of the general condition, and, in favorable cases, the palpation of indurated nodules.

It would be interesting now to look over the tabulated series of cases of primary carcinoma of the ovary which I have been able to collect from literature, but lack of space prevents their publication at this time.

THE PHYSICIAN IN PUBLIC AFFAIRS.

BY F. PARK LEWIS, M.D., BUFFALO, N. Y.

THERE is not infrequently a feeling, although it may not be consciously recognized, that the profession of medicine is so thoroughly distinctive and apart from other lines of human work that the medical man who allows his interests to extend beyond the narrow limits of his daily routine duties and actively occupies himself in general political or literary affairs is in some way rudely violating the traditions of his cult, and that other and occult reasons must prompt his actions, rather than those which are manifest.

It is this unwritten but none the less sensible sentiment that tends to narrowness, not alone of the profession, but primarily and necessarily of those by whom it is followed; because while it is a truism that concentration is the essence of successful accomplishment, it is not less a fact that the part is more clearly comprehended by the understanding of its relation to the whole, and the broader the general culture the more exact the specific knowledge. Indeed, it almost follows as an inevitable conclusion that the habit of precise thinking in one line carries with it an accuracy of discrimination in all others. In a profession making such continuous and exhausting demands upon the strength, the intellect and the emotions as that of medicine, in which the element of personal touch enters as such an essential integer, the relief, the greatest relief, which the weary brain requires and which the strained sensibilities demand is not that of quiescence, of inactivity—the enormous nervous voltage generated by a struggle enduring day after day for weeks, in an almost hopeless endeavor to save a human soul from slipping over into the great beyond, and the harder task of bearing the dead weight of the anxious, terrified relatives—the momentum, I say, of this nerve force cannot be stayed, often even sleep refusing its comforting ministrations; but it can be diverted into harmless channels, giving productive and valuable results where it would otherwise be destructive.

A diversion of interest is not incompatible with the highest medical skill.

Virchow found time to enter the Bundesrath and give to his country the ripe results of a trained mind while remaining the foremost pathologist in the world. Wier Mitchell, the dean of American neurologists, for a pastime wrote novels which placed him easily among the foremost of the litterateurs of to-day. One of our own number, than whom none of our day has done more for scientific *materia medica*, amuses himself by studying the laws of harmony and thorough bass and adding to our knowledge of the *algæ*. Dr. Harrison Allen, of Philadelphia, lived a dual life. He was known in the laryngological world as a skilled specialist in the morning, but after one o'clock he was an entomologist—was it not?—and eminent in both departments; yet so separate were his interests that many who knew him in the one field of activity had no knowledge of the other side of his work. One of the most celebrated special workers in New York City is also a marvellously expert billiard player.

The physician is wise who has some thought which is foreign to that which usually controls him. If he has no special predilection, a line of investigation which is nearest and in which he may be most practically useful—one for which his reading and his training most efficiently fit him—one on which the public naturally look to him for advice and assistance, is that touching the general sanitary affairs of the community in which he lives. Circumstances usually force a few men to take sanitary control of a village or municipality, and the thoroughness with which the laws of *hygeia* are administered rests almost wholly with these men. Happily, in many instances the laws are reasonably well administered. Such vital matters should not be referred to State or local health boards, however, but to the executive officers of the intelligent medical sentiment of the community; and in many instances the demands of the people, as voiced through their medical representatives, are necessary to keep their officials up to a full realization of their duties. The problems presenting are as important as they are numerous. The water-supply, its source and delivery; public filtration, its practicability and its necessity; private filtration, when inefficient, worse than none; diseases due to water im-

purities—each of these may be local problems having special importance; *e.g.*, the garbage and sewage question, the efficient and economical disposal of waste matters, are of primary importance. We should be able to trace back to a non-tuberculous and otherwise clean and healthy cow, through the various hands it passes, the milk which is daily delivered at our doors. The sanitation of our schools and other public buildings is a fascinating field for investigation and study. Inquiries conducted by a committee of citizens in Buffalo last year—and Buffalo is far in advance of most municipalities in sanitary matters—made evident a most shocking condition of some of our public schools; and yet, doubtless, like defects might be found in the city and State schools generally. Thousands of dollars have been expended on systems of ventilation that, when tested, were found to be thoroughly inefficient and useless. Exit-stairways in some cases were so narrow that a conflagration would have become a holocaust. Indecencies were necessitated by lack of closet facilities, and other sanitary defects were discovered that were as obvious as they were obnoxious. The study and correction of these defects belong to the physician. It is to him that the public look for instruction on these lines.

Of equal importance, and perhaps of greater interest, is the study of the effect of school life on the child. Is the physical side receiving equal attention with the mental? Are the school desks and seats suited to the height of the child, or are plastic bodies developing rounded shoulders and crooked spines and near-sighted eyes? Is the competitive element straining the nervous system beyond endurance—laying the foundation for future disease? Are the frequent regents' examinations and scrolls of manuscript desirable, or, from a medical standpoint, are they to be deprecated? Many of the most careful students of pedagogy are making exact observations on the normal child, and rest and fatigue are being discriminately analyzed. The pedagogical is but one side only. The teacher's work should go hand in hand with that of the physician, so that the one set of observations may act as control tests to the other. There may be conflict, too, between a too paternal government in its endeavors to educate and protect its people and those whom it governs.

Wholly aside from the merit and efficiency of vaccination as a prophylactic measure against small-pox, it is a grave question, and one which should be tested, whether the State is not far exceeding its privileges and infringing on the constitutional prerogatives of the individual when it forcibly compels the inoculation of a virus, the effects of which may be serious injury, if not, as sometimes occurs, death, and making its evasion practically impossible—on the one hand preventing attendance at school until this rite shall have been performed, and on the other making attendance upon school a compulsory duty. These are subjects demanding the attention of some members of the profession. Why should not public sanitation or some congenial phase of city or State hygiene be the diverticulum into which the physician wearied by many anxieties and much burden-carrying can enter for helpful rest? I say, then, that in societies like this the Bureau of Sanitation and Public Health should oversee a larger part of the careful and systematized work performed. It would be desirable at each meeting of this body to take for its study some special department. Let it be, for example, School Sanitation; and let us not be satisfied with its discussion merely, but, by dividing the labor, let us learn not alone what it should be, but what is in the public and normal schools throughout the length and breadth of the State of New York. Let us learn not alone what the children *should do*, but, as well, what they *are doing*. Let us study the curricula from a physiological and a medical standpoint. To inaugurate a great work of this kind, committees and sub-committees should cover the whole State. It should include in its number those who are not members of this society, in order that the largest work should be accomplished—practical trained teachers who are as interested as we are in getting the best; sanitary engineers who can get for us facts that might not occur to one of us; lawyers who can advise us as to a right method of procedure, in order that the data which we accumulate may be utilized. Then, having determined where gross errors exist (and a partial investigation has demonstrated that they are omnipresent), let this powerful influence, thus aggregated, be directed toward a correction of the evils. Let us see to it that modern school architecture is in harmony with modern scientific thought; that the education which the State is giving its children will con-

cern itself not alone with their mental development, but with their physical well-being also. The effect of such a movement, rightly planned and suitably carried out, would result in a benefit to our citizens which would be simply incalculable. Let us not be satisfied with the discussion of such problems merely, *but become an efficient working force.*

This is but one, and that in briefest outline, of many such questions that are constantly presented to the medical citizen. Is there any good reason why this body should not start the machinery in motion, the working of which may serve to uplift and strengthen humanity by the establishment of scientific methods, the consequences of which may be beyond our possible conception? I submit the proposition for your considerate discussion.

THE CAUSTIC ACTION OF ARSENIC IN TREATING CARCINOMATOUS GROWTHS ACCESSIBLE FROM THE SURFACE OF THE BODY.

BY C. W. SIMMONS, M.D., PHILADELPHIA.

FROM my personal knowledge of carcinoma, and from extensive reading on the subject, I cannot but believe that, while there exists a constitutional state that permits of the development of this disease, for all practical purposes of therapeutics it is, in its very earliest stages, essentially a local affection. While its symptoms are possibly remedial by both homœopathic as well as allopathic measures, the disease itself is only attackable in a surgical manner. Now, my idea of the surgery of most cases of cancer is that the caustic treatment is, for many reasons, preferable to the use of the knife.

Caustic treatment, however, appears to be almost entirely relegated to the province of the cancer doctor or quack, and it is time that the treatment of so serious a disease should be undertaken by more competent and responsible parties. Medical men, with few exceptions, have shown no disposition to ascertain whether there was or was not any virtue in the treatment pursued by these so-called cancer doctors, but are content to rely upon the knife to accomplish what the patient is told is the "only chance to cure." When we take into consideration the ter-

rible responsibility we are called upon to assume in the treatment of cancer, are we justified in saying to our patient that the knife offers the *only* weapon we can effectively wield to combat this disease? I believe lack of success with this caustic treatment in the hands of some medical men has been due to the absence of care and caution in its application, and thus it has been allowed to fall into disrepute and into hands of irresponsible parties. We are told that the lymphatics are the channels through which the infection spreads, and that therefore any *local* treatment cannot rid the system of the trouble. The knife is local treatment, but is it a surer remedy than caustics?

Carcinomatous growths are not encapsuled, are heterologous and grow by invasion of the surrounding normal tissue, and it is left to the surgeon's judgment as to how much healthy tissue should be removed at the time of operation, and too often enough of the neoplastic cells are left to enable the growth to start up again later on. *This is the principal objection to the knife.* I do not mean to be understood as claiming that a cutting operation is never desirable, for there are many cases of carcinoma where, by reason of the location of the growth and surrounding structures, it is undoubtedly the best means at our disposal; but in skin growths, and others even more deeply seated (as in case of the breast), that are accessible from the surface of the body, my experience, and a careful inquiry into that of many competent clinicians, has demonstrated the caustic treatment to be extremely valuable when applied in the *early* stages, and to effectively accomplish the destruction of the growth, projections into the healthy tissue, and all. When I say "effectively," I mean the growth has not returned in two years.

The great difficulty is that most caustics not only destroy the diseased tissue, but also set up an inflammatory action in the surrounding healthy tissue that is often likely to be hard to control. It is very necessary, however, that the normal healthy tissue should be reached sufficiently to destroy the offshoots of the growth, and *herein lies the advantage of the application of a caustic over the knife.* Arsenic is the ideal caustic, as it acts better than any of the others. It is well known that neoplastic tissue has feebler power of resistance to injury than normal tissue, and with care in the application of arsenic *we can pro-*

duce in the surrounding healthy tissue just sufficient inflammatory action to destroy the carcinomatous cells and permit the healthy tissue to be restored to its normal condition upon removal of the caustic ; whereas by the knife such offshoots must be vaguely sought for, as the judgment dictates, at the expense of much good, sound tissue, and a resulting large, ugly wound, to say nothing of the mental agony a patient goes through in anticipation of a cutting operation, which every patient looks upon with dread.

The arsenic can be used in various forms, but is best and more conveniently applied in the shape of a paste spread on a piece of cloth. The inflammation it causes is just sufficient (when judiciously applied) to destroy the neoplastic tissue embedded therein, and yet not to cause necrosis of the healthy tissue.

When cautiously applied (*i.e.*, when the strength of the paste is regulated by the patient's probable susceptibility to the arsenic), and the physician is watchful, I have never observed any absorption of the poison or other bad results, and I have used it in some thirty-five cases of carcinomatous growths on various portions of the body accessible from the surface. For *internal* growths I have never attempted treatment either by this or any other caustic, hypodermatically or otherwise.

As in the early stages cancers, I believe, are only local, to get results the arsenic must be applied before lymphatic involvement. After the lymphatics are affected the caustic treatment is no more effective than other means resorted to, for it naturally cannot rid the system of the poison.

The caustic treatment of cancers has the disadvantage of being more painful than the knife, but this varies with the area and depth of the growth and with the length of time the plaster must remain in place. An anodyne of some unobjectionable nature is occasionally necessary for the patient's comfort. What this shall be the physician is, of course, best qualified to judge. The pain at first is intense, but gets more endurable after a few days. Usually one of the first symptoms to manifest itself in peculiarly susceptible individuals is gastric irritability, but this need never become of a pronounced nature, if promptly and skillfully treated medicinally. I have always been able to hold it in control, when it occurred, by looking after it *promptly*.

The most important factor in the treatment, however, is free

movement of the bowels, to remove the products of retrograde metamorphosis. Indeed, if this is not looked after, the patient's condition is likely to develop a serious turn. The only instance where serious results were noted was in one case where the patient was under the direction of another physician, who failed to pay more than passing notice to the alvine discharges, allowing the bowels to move say once in two days. The woman developed an arsenical neuritis, which, however, was gradually overcome after free catharsis had been established at my suggestion, diuretics administered, and electricity and other remedial measures employed; but she finally succumbed from cardiac complications after the plaster had come off and the wound was almost entirely healed. The bad results in this case were clearly traceable to neglect of, or lack of proper attention to, the bowels.

It has been my fortune to have a number of carcinomatous cases to treat under this method, both for myself and other practitioners, and I have uniformly found good results to follow when physicians carefully watch the patients. In many cases I have attended, the plasters have been applied *after the return of the growth following operation*, but I have not observed any benefit from caustic treatment at so late a date. In fact, most such cases have died from secondary internal growths. The caustic must be applied *early*, just when we are recommended to use the knife, before the infection has likely had opportunity to infect the system.

I employ the pure powdered white arsenic, which is mixed up into a paste with water and flowers of sulphur, which latter is used simply as a diluent to regulate the strength of the plaster, as deemed wise according to the probable individual susceptibility of the patient. For most cases, the proportion of 50 per cent. arsenic will do. Some need stronger and some weaker pastes. Occasionally I have added a little cocaine for the relief of pain, but have seldom found it necessary.

The plasters are spread on a piece of cloth and applied to the unbroken skin, and in most cases are allowed to remain *in situ* until they drop off with the slough (which is anywhere from four to six weeks), when the wound is treated as any open suppurative surface. Applications must necessarily cover a larger area than the growth proper, in order to include its various branches and projections. For a few days after the

plaster comes off the wound is carefully washed with peroxide hydrogen and dusted with puronal, after which an application is made of balsam Peru and castor oil. The latter is the most satisfactory dressing I have ever employed for this purpose, as it has the advantage of keeping the wound antiseptic and avoids all bad odor, besides stimulating granulations.

To sum up, the advantage of arsenic locally in the treatment of carcinoma over the knife is that we can by this agent positively eradicate every vestige of the growth, *when applied early* with judgment and care, while with the knife it is never *positive* that all the carcinomatous cells have been removed, and the dread of a cutting operation is also avoided.

CARBOLIC-ACID POISONING—REPORT OF A CASE—RECOVERY.

BY EDWARD M. DEACON, M.D., BIRDSBORO, PA.

JUDGING from the number of cases of carbolic-acid poisoning which are reported from time to time, this popular antiseptic agent seems to be developing an unenviable reputation in this particular sphere.

Statistics compiled by Mann* show that one-third of the males and very nearly one-half of the females who poisoned themselves in 1895 did so with carbolic acid. He thinks the list of cases would not be so large were the sale of this poison restricted by law.

The symptoms produced by any appreciable quantity of this drug are severe and speedily point deathward, and in order to be combated successfully, early and energetic treatment is necessary. But even in those cases which are seen early the prognosis is extremely doubtful.

The case which the writer desires to report is as follows:

In November, 1895, I was hastily summoned to attend Mrs. G., aged 50 years. On entering the room I found her lying upon the floor unconscious. The face was cyanotic; the forehead was covered with a cold sweat; the pupils were contracted; the pulse was very rapid and hardly perceptible; the

* *Medical Chronicle*, December, 1896.

breathing was slow and very shallow; the jaws were so tightly closed that considerable force was required to open them; swallowing was present, though very irregular and hardly noticeable; the lips and buccal cavity were white; the breath had the odor of carbolic acid. Some women who were present stated that the patient had been seen in the yard of her home at 11.30 o'clock A.M., and that she had been discovered lying upon the floor by her daughter, who had returned from school at 12 o'clock. The alarm was given immediately. It was fully ten minutes later when I arrived. A half-pint bottle containing one ounce of pure carbolic acid was found on a chair in the room.

Treatment.—The clothing about the neck, chest and abdomen was loosened. A hypodermic injection of brandy was given and artificial respiration resorted to. As there was no tubing at hand that could have been passed into the stomach, the writer concluded that the risk of strangulation from the liquid was less than that of allowing the œsophagus and stomach to become an easy prey to the unrestricted action of the poison. The patient's head and shoulders were slightly raised, and after forcing the mouth open, and keeping it so by means of an artery-clip covered with absorbent cotton, a mixture composed of equal parts of milk and sweet-oil was slowly poured into the mouth until one glassful had been given. This followed the channel to the stomach without incident, though it was given very carefully. Apomorphia, one-tenth grain, was injected into the abdominal tissues in the epigastric region. No vomiting having occurred five minutes later, another injection was given in the same region. Still there was no vomiting. Sulphate of zinc was then procured, and twenty grains were dissolved in a little milk and administered by the mouth. This was followed by more of the milk and oil mixture. Stimulation and artificial respiration were kept up unceasingly. About ten minutes after the sulphate of zinc had been given vomiting commenced, and was quite profuse. The vomited matter was dark and rather thick. More sulphate of zinc was given, followed by more of the mixture. The vomiting continued at short intervals. The patient was catheterized, a small amount of urine being withdrawn. Its appearance was normal.

By this time the patient began to exhibit more signs of life. The pulse and the breathing were better. About 3 o'clock in the afternoon she began to notice her surroundings, although she could not speak above a whisper, and complained of an intense burning in her mouth, throat and stomach. Every few minutes she was given a swallow or two of the mixture, in order to soothe the painful surface. At 6 o'clock her condition was greatly improved. The bowels became quite loose. There was considerable burning in the rectum after the stools had passed. Morphine, hypodermically, was now given. This eased her pain somewhat. She continued to improve, and was attending to her household duties on the fourth day. Her diet until then consisted of milk, corn starch and junket, frequently repeated. I received reports from her every few months until a little over a year ago. Since then I lost track of her. Her last report stated that she had no discomfort then.

As to the quantity of the poison swallowed, it appears to have been considerable. The patient acknowledged that she had tried to destroy herself. She stated that the bottle was not quite half-full when she picked it up, and that she drank all but what remained. There was no evidence upon the floor, which was bare, or upon the chair, which was a wooden one, indicating that any had been spilled. Thus we can roughly estimate, if her estimate is to be believed—and I have no reason to doubt it, as the symptoms show—that she took between one and two ounces of the poison.

An interesting feature of the case was the inability of the apomorphia to produce emesis at a time when its prompt action was needed. This fact naturally leads us to two thoughts, viz., that an antidotal relationship exists between the two drugs, or that the apomorphia was not fresh. The tablet used was of a reliable make, and had been bought only the week before. It will be well, however, to remember the possibility of an antidotal relationship existing between the two drugs.

The possibility of a stricture of either the œsophagus or stomach following the healing of the eroded membrane was prominently in my mind. But the subsequent history of the case up to the time of the last report excludes the presence of this condition.

Since treating this case I have seen the claim made that vinegar is a specific antidote to carbolic acid. I have had no opportunity to use it, hence cannot speak for it; but I do think my patient would have died had I not used the mixture composed of milk and sweet oil, as already mentioned, and were I called to a case of carbolic-acid poisoning now, I would use the very same means as I did then.

TINNITUS AURIUM.

BY WM. SPENCER, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society, State of Pa., Pittsburg, Sept., 1898.)

ONE of the most troublesome conditions the aurist is called upon to treat, and for which a great many remedies have been proposed, is tinnitus aurium.

It is a frequent symptom in many diseases of the external, middle and internal ear, and may originate from diseased conditions, not only in the various parts of the organ of hearing itself, but also in other parts of the head and body, being transmitted to the ear either directly along mechanical channels or indirectly by reflex action from the sympathetic and cerebro-spinal nerves to the auditory nerve.

Field, of London, "gives as the chief causes of subjective tinnitus:

"First. Abnormal pressure on the labyrinthine fluid.

"Second. The reflex causes which act on the nervous structures or on the labyrinthine circulation.

"Third. The entotic sounds; that is, those resulting from sonorous vibrations originating either within the ear or its neighborhood."

According to the observations of different aurists, from 25 to 33 per cent. of all ear patients suffer from subjective noises in the ear.

The condition is more marked in the decline of life, for in childhood the exanthemata and naso-pharyngeal affections are the chief diseases which frequently become the source of affections of the ear.

While the frequency of ear diseases decreases in the prime of life, it presents, again, a noticeable increase in advanced age, not only in consequence of retrograde changes in the ear similar to those in the other organs of special sense, weakening the power of the auditory nerve, but also frequently—owing to the development of chronic insidious inflammations of the middle ear—leading to thickening of the lining membrane of the tympanic cavity and to rigidity of the articulations of the ossicles.

The subjective sensations of hearing are characterized by the patient in different ways, not only in intensity and constancy, but also in quality and pitch. Of course, imagination plays a large part in the description by the patient of these subjective phenomena, and it will usually be found that he likens the noise in his ear to external sounds with which he is familiar, being largely influenced by his personal experience and environment. In cases of this kind, while we are dependent upon the descriptive ability of the patient, we must not accept the statements that are made as an altogether safe guide in diagnosis. Nevertheless, they furnish useful hints as to the causation and the probable pathological condition existing, and it would be wrong to reject them entirely.

Dr. Peter Allen wrote: "As chronic catarrh is the most common form of deafness, so is tinnitus aurium the most frequent result or sign of it. It is dependent upon some abnormal pressure upon the nervous expansion in the labyrinth. The membrana tympani presses the ossicles, and therefore the base of the stapes, inwards upon the fluid when the auditory nerve is disturbed, or it may be so rigid, tense and unyielding that the secretions within the drum press unduly upon the still more delicate membrane of the fenestra rotunda.

"Thickening and great tension of the lining membrane do the same thing.

"Next to interference with the membrana tympani, closure of the Eustachian tube is the most common cause of singing in the ears. A closed tube necessitates a too great curvature inwards of the membrana tympani, and consequently an abnormal pressure upon the nervous expansion within the labyrinth."

Tinnitus of a pulsating or beating sound, especially if occurring with the movements of the heart, is referable to vibrations

set up by the passage of blood through the carotid artery, jugular vein and the vessels of the internal ear, and transmitted to the internal ear either through the ordinary channel or through the tissues of the head. This motion is sufficient to excite the auditory elements by causing vibrations of the intra-labyrinthine fluids, and so produce sound, which, being a normal condition and one to which the ear is accustomed, will remain unnoticed.

But let this movement be increased by stooping, by physical exertion, by mental excitement, or by any cause intensifying the circulation in the vessels of the head and neck, and at once the abnormal condition draws our attention to it.

Tinnitus is due either to increased sensitiveness of the auditory apparatus, or, more likely, to changes in tension in the sound-transmitting apparatus, by thickening of the soft tissues of the middle ear, impacted cerumen, a swollen canal, or exudations and adhesions—the result of chronic catarrh, etc.—which, by interfering with the aerial condition of sound, at the same time facilitates the conduction of vibrations through the tissues of the head.

These sounds—the most common variety—are generally described as similar to the sound of distant rumbling or as to the noise of the ocean, and are associated with the movements of deglutition, of mastication and of respiration.

Tinnitus may result from an increased pressure of the intra-labyrinthine fluids, the result of thickening, increased blood-supply, hæmorrhage or exudations, or it may be due to an opposite effect—a diminished intra-labyrinthine pressure, caused by a loss of intra-labyrinthine fluid or by a lessened blood-supply to the internal ear. Examples of this would be in cases of anæmia and in a famishing person.

Tinnitus of myringitis is seldom absent, varying in accordance with the intensity of the morbid process going on in the tympanic membrane.

Diseased conditions of the auditory nerve in any part between the internal ear and the brain centre may cause a pure subjective tinnitus. However, so little pathological research has been made in this direction that the field is very obscure; but, reasoning by analogy, the auditory nerve may be subject to as many diseased conditions as that of the optic nerve, al-

though, from its anatomical location, they are not capable of demonstration.

From this variety of causes it will be seen that the treatment of tinnitus aurium must be as various as is the cause, and that success in its treatment in each individual case must depend upon a correct understanding and diagnosis of the cause which produces it. The keynote to the success in treatment is to remove the cause, whatever that may be, whether due to foreign bodies in the external meatus, congestion or inflammation of the membrana tympani and external meatus, anæmia, reflex irritations from the nose, teeth, hæmorrhoids, etc., pulsations produced by pressure on the arteries of the ear, diseases of the heart, or middle-ear secretion due to otitis media.

The most frequent cause of tinnitus is associated with the different forms of otitis media, causing a local tympanic congestion, and not only interfering with the normal arterial flow, but to the extension of the irritation and pressure to the inner ear. This condition and result are very evident when we consider the pathology of acute suppurative inflammation of the middle ear.

“First, there is hyperæmia, and consequently hypersecretion from the mucous lining of the Eustachian tube, tympanum and mastoid cells. The swelling of the tube tends to lead to retention of the secretion, and to strangulation of the veins and lymphatics which pass from the middle ear to the nasopharynx. As the inflammation increases, a larger number of leucocytes than normal migrate from the vessels into the tympanum and the vitiated epithelium is shed. This secretion, if prevented from draining through the Eustachian tube, is retained; the cells of this retained secretion undergo fatty degeneration, and ulceration of the lining membrane takes place. The hyperæmia often extends by continuity to the labyrinth.”

As a result of this inflammation, the tympanic contents are incapacitated for vibratory transmission by bands and masses of fibrous tissue, so that the physiological functions are rendered almost nil.

Now, this common factor in the production of tinnitus aurium should, by analogy, be amenable to treatment by any drug combined with the use of certain mechanical measures, such as the inflation of the middle ear, and passive motion of the

membrana tympani that will produce a softening and absorption of cicatricial tissue. The writer's attention was called to such a drug by observing the result obtained from the use of thiosinamine in the successful treatment of keloid, lupus, chronic glandular swellings, removing scar-tissue and the power of softening cicatricial tissue. Messrs. Merck & Co., New York, kindly furnished me with the following brief *résumé* of the physiological action of the drug:

"Thiosinamine (allyl sulphocarbamide) is derived from the oil of mustard-seed. It belongs to the same chemical group as urea. The colorless, bitter crystals are soluble in water, alcohol and ether. The dose usually is from 4 to 8 grains once a day in 15 per cent. solution, hypodermically."

"Dr. H. von Hebra, Jr., of Vienna, employed the remedy in a number of cases of lupus, 3 minims of the liquid, gradually increased, being injected into the back two or three times a week. These injections did not provoke any general reaction, save occasionally accelerated respiration, and never any alarming symptoms; on the other hand, a distinct local reaction set in after a few hours, rubescence, swelling and tension of the skin of the lupus area. As a rule, a sensation of heat and of tension was also experienced in the affected parts, but this disappeared soon.

"The urine was augmented in quantity, the patients voiding on the day of the injections 200 to 500 c.c. ($\frac{2}{3}$ to 1 pint) more than usual without anything abnormal being observed with the kidneys themselves; the urine contained neither albumin nor formed elements. On the other hand, the injections determined an improvement in the general condition; the appetite was augmented and the bodily weight increased.

"The effect of the remedy was also noted by another observer in 30 cases of glandular swelling in children, and in all these the results were excellent. The injections of the remedy were well borne, on two occasions only an urticarial eruption having supervened, and which disappeared without treatment. The remedy was used in doses of from 16 to 80 minims of a 5 per cent. solution injected twice a week under the skin of the intrascapular region, alternating between the right and left sides."

Dr. Sinclair Tousey, who has made a very careful study of

this drug for the past four years, says: "It would appear that thiosinamine sought out the disease, in whatever part existing, and destroyed it."

This sounds rather extravagant, but mercury and arsenic and iodide of potassium and a good many other drugs might be said to have the same power. The idea is, that this drug sets up an unusual cellular activity in the blood and in the lymphatic and connective tissues which are the nurseries of leucocytes, and that lowly-vitalized tissue (*e.g.*, cicatricial tissue) is affected wherever it may be located. My experience with this drug in this disease has been too brief to give a tabulated report of cases. I have used it during the past six months, selecting several cases (nine) where the conditions seemed to favor such a course of treatment, with results which have been so satisfactory and gratifying as to justify me in saying that it is a drug that should be most thoroughly investigated, and that it may prove a valuable addition to our list of remedies for this troublesome and distressing disease. I am free to confess that I have had more failures than successes in the treatment of tinnitus aurium, and that I have no reason to feel very much enthused over any one special line of treatment for all cases; but where the ossicles are bound down and the functions of the tympanic cavity so much impaired by fibrous bands and adhesions, this remedy will suggest itself to me.

It may not be able to entirely stop the tinnitus, but in many cases the very turbulent noises can be so diminished that they may be borne by the patient.

ALCOHOLISM.—A case of acute alcoholism may at the same time be one of apoplexy. One suffering from an apoplectic attack may have the smell of liquor on his breath and yet not be intoxicated. The breathing in a case of acute alcoholism, while it may be deep and heavy, is not truly stertorous, nor of the Cheyne-Stokes variety, and examination will not reveal paralysis of one side of the body. Consciousness may appear to be lost, but it is not absolute, and the patient can generally be aroused, at least for a moment, from his stupor. The pupils are usually equal and dilated. The temperature may be two or three degrees below normal, but it does not show the successive variations of true apoplexy. Southey has recommended the injection into the rectum of a pint and a half of cold water, with a tablespoonful of salt dissolved in it, which once restored to consciousness a case of extreme drunkenness.—Dr. Mill, *Quarterly Jour. of Inebriety*, October, 1898.

EDITORIAL.

WM. H. BIGLER, A.M., M.D.

WM. W. VAN BAUN, M.D.

A HAPPY NEW YEAR.

It seems but as yesterday that this Journal was called upon to extend its New Year's greeting to its friends and readers (not always coextensive circles, alas!) and to wish them all a happy New Year. We trust that all have found it such.

Amidst rude war's alarms the HAHNEMANNIAN has been able to glide smoothly along, as if with ball-bearing gear and best pneumatic tire unpunctured, until its cyclometer, on the first page of its cover, proudly registers Vol. XXXIV.

With malice towards none it has honestly endeavored to criticise subjects of seeming importance from an impersonal standpoint. In the gradual development of tendencies, and in the onward progress of the Spirit of the Age, the single individual factor must be regarded as of too little importance to influence the judgment. This Journal always has struck and always will strike for what it considers the right and the truth, without regard to persons, and indeed totally and designedly ignoring them, since it is measures, not men, which are the objects of its criticism.

With a *mens conscia sibi recti*, it hopes that all whose eyes these lines may reach may have as happy a New Year as it looks forward to for itself.

SHALL THE CURRICULUM OF THE MEDICAL COLLEGES BE FURTHER EXTENDED?

IN the *Medical Century* for November 1st we have an interesting paper by Dr. T. P. Wilson, entitled *In Time of Peace Prepare for War*, in which he attempts to formulate a certain definite line of action whereby Homœopathy shall better be able to gain recognition in the service of the army and navy of the United States.

His suggestions are as follows: A new literature must be created, "wherein our claims to recognition shall be set forth in popular form and plain language;" further, "our literature should be enriched by the production of text-books on war, medicine and surgery," and minor treatises on army hygiene and kindred subjects should be prepared for officers and soldiers; "there should be prepared a complete outfit of war medicines—a war chest, for instance, to contain the necessary remedies, say in tablet form, from the unmixed drug up to any required attenuation of the same, as well as those drugs required for external application;" also, "each soldier or officer should be supplied with a small pocket-case of remedies to be used in emergencies, according to simple directions contained in a small pamphlet to be included in each case. Finally, although it is the second suggestion on the doctor's list, "all colleges must add to their course of study a department of War Medicine. Such a course might be made special; and to those students completing this course there should be awarded a diploma."

In a letter to the *North American Journal of Homœopathy* for December, from Dr. Custis, of Washington, the following suggestions looking to the same end are advanced.

First, Accumulate evidence that no well-organized school could have done worse in the late war than was done by the one in power.

Second, Accumulate evidence that homœopathic methods have always made a better showing than those of the dominant school where they have been adopted in institutions wholly or in part under State or Governmental control.

Third, "Let each College make special provision for teaching the principles of military and naval hygiene, and the peculiar methods, executive and special, adapted to the needs of the Army and Navy."

While among Dr. Wilson's suggestions there are some eminently practical and easily combined in their execution with the first two suggestions of Dr. Custis, there are some—those referring to the preparation of a war chest and cases for soldiers or captains—that seem to us visionary and impracticable. We will not, however, enter into a discussion of these at the present time, but confine ourselves to the suggestion common

to both that each college shall introduce a new course of study into its curriculum, bearing particularly upon war medicine.

We are decidedly not in accord with this proposition, first because it is unnecessary, secondly because it is impracticable, and thirdly because it is unjust.

1. It is unnecessary. Every school has at present in its curriculum lectures on Hygiene and Sanitation wherein the general principles, and no doubt many of the details, of these branches as applied to masses of men, whether in hospitals, prisons, or barracks, are taught. We do not believe that there is an exclusively homœopathic way of treating these subjects, and the only possible reason for further special attention being devoted to them would be to apply them particularly to the needs of the military and naval service. This is rendered unnecessary by the provision that after a graduate of any legally recognized medical college has successfully passed an examination as to his fitness for service in the United States Medical Department, and has received his appointment, "he is required to attend the army medical school of Washington, where he receives instruction for four months in the ways of adapting his medical and general knowledge to the requirements of the military service." (We quote from an exceedingly lucid, dispassionate and exhaustive paper on *The Army Medical Department*, by Dr. Charles Adams, in the *December* number of the *Medical Era*, from the perusal of which we have obtained a clearer, and we trust a juster, conception of the whole question than had been possible from the hysterical accusations and scattered refutations in the daily press during war times.) Surely this provision would obviate any necessity for a special course in our own colleges.

2. It is impracticable. We do not wish to be understood as meaning absolutely impracticable, for it is manifestly impossible to determine with absolute certainty the exact point at which the weight of the feather will be sufficient to break the camel's back. The curriculum is already sufficiently well padded with specialties in addition to the fundamental and necessary branches of a medical education; indeed we might well ask whether it is not perhaps too well padded, for comfort surely, if not for utility. With the time at the command of the colleges, and with even the best available material at hand

in the way of students, the danger of turning out widely but superficially educated practitioners is every year approaching completer realization. The same trend in the direction of the many, away from the much, from a solid useful knowledge of a few things to a useless smattering of many, so glaringly apparent in the common-school system of the present day, is making itself evident in our colleges to the detriment, as we think, of true education, medical and otherwise. Neither curriculum nor student should be burdened with another specialty.

3. It is unjust. It would be unjust to those students who have no intention, either near or remote, of ever applying for admission to governmental service. They have come to college to acquire a medical education which shall qualify them to become general practitioners, and any arrangement of the curriculum which shall in any way interfere with the expressed and implied agreement of the college to furnish them with this must be regarded as unjust, if not dishonest. It matters not whether this interference takes the form of wasting their energies on subjects useless for the purpose they had in view in entering college, or in the form of devoting undue attention to subjects which are of special use to only a few. We could not regard the carrying out of this proposition as anything less than a piece of rank injustice to the great mass of students, particularly since even its general utility, in the light of what we have said above, is more than problematical.

It is true Dr. Wilson says, "Such a course might be made special;" we would rather say *would have to be made* special and elective; and with a government school in existence under instructors experienced in the requirements of military service which the accepted graduate is compelled to attend, methinks but few would elect such a course in our own colleges, no matter how well qualified its civilian instructors might be or might seem to be.

We therefore do not think it is necessary, practicable or wise for our colleges to add a new course on war medicine to their curricula.

ACETATE OF THALLIUM IN ALOPECIA.—Dr. Huchard recommends this remedy in the night-sweats of consumptives, but warns against continuing it for more than three or four days, for it has the inconvenience of causing *the hair to fall out en masse*.—*Académie de Médecine; L'Art Medical*, No. 5, 1898.

GLEANINGS.

THE MEDICAL TREATMENT OF APPENDICITIS.—Dr. Elmer E. Lee, New York, says: "As soon as the physician suspects even that there is a possibility of appendicitis, upon first seeing his patient, the safe course is to be on the defensive, and by this is meant to treat the patient, rather than the disease, with the view of preventing that which is suspected, or if too late for that, proceed in such a manner as to actually give the best chances for a rapid recovery, and thereby provoke the least damage to the abdominal viscera.

"In all acute inflammatory diseases of the intestines experience proves that food should be withheld from the patient for one, two, three or four days. In cases where fever is a prominent symptom the precise and life-saving course warrants the forbiddance of all food so long as the elevated temperature remains. All alimentation, either by mouth or rectum, can be but partially digested and assimilated during the active stage of inflammation.

"From the beginning of the treatment six to eight ounces of fresh, pure water—administered with disciplinary regularity each half-hour or each hour for the first, or first and second days of treatment, then if the case improves let the interval be two hours—is a therapeutic resource of striking simplicity and exact scientific value. The only valid counterindication is the use of discretion in disturbing the patient should he be asleep; none other exists to my knowledge. In the selection of potable water for clinical use distilled water gives the best results.

"It has been observed that a free use of pure water is an effectual laxative, obviating more drastic methods. The laxative effect is aided by dissolving small pinches of common salt in draughts of hot water, given at the regular intervals. Purgation is desirable, but when the intestine is undergoing active inflammation harsh purgatives are seemingly useful, but actually harmful. This is owing to the irritation excited in the mucous walls of the intestines, and also to the fact that the purgation is at the expense of the constituents of the blood.

"The hot saline or soapy enema will free the colon by quickly washing down the faecal contents. The small intestines need no purging, for fermentation and decomposition are generally to be looked for in the ascending and meso-colon. Such cleaning of the small intestines as may be useful will naturally follow upon the administration of hot water by the mouth, and from the effects of hydrostatic enteroclysis. It requires two to three quarts of solution to ascend the colon and reach the cæcum in an adult, and one-half the quantity in a child. Irrigation is best given in the knee-chest position, though it is immaterial in what position the water enters the colon, so long as the quantity introduced is sufficient to partially distend the bowel all the way up to the cæcum. It may not be able to accomplish this satisfactorily in all patients, or perhaps not at the first trial. But the water can be made to go

to the cæcum and do its bidding as far as the opening of the appendix, if used with a little patience and perseverance. The colon, freed of its contents, is an important beginning in the management of acute appendicitis as well as in other forms of enteric inflammation. A short rectal tube four to six inches long, of large caliber, is the one now commonly used; the long tubes are no longer generally employed. Water with pressure behind it will find its way more safely and naturally without the use of a special colon tube, which in practice may buckle and get no farther than the rectum or first fold of the sigmoid flexure.

"In severe cases of painful appendicitis cold water applied to the affected area of the abdomen is grateful to the patient and helpful in allaying both pain and excessive heat, consequently such applications aid in hastening restitution of the inflamed appendix. My favorite compress is a small napkin saturated with ice-water, frequently renewed, with a piece of flannel laid over it as a protective against wetting the bedding. Extreme care that the comfort of the patient is not too much disturbed by leakage in the bed is most important. The ice coil and the ice bag, if not too weighty, are convenient and useful. Gentle massage of the abdominal wall contiguous to the appendix is beneficial in cases where the inflammation is not of the fulminating character. Sometimes a cold compress may be advantageously followed by one wrung out of hot water. But where there is excess of local heat with fever the cold works better, all things considered.

"Chronic cases should come under a modified plan of treatment based upon the principles herein set forth, and kept within the control of the physician till all the symptoms are long since passed.

"First, of regularly cleansing the colon once a week by the hydrostatic injection of two to three quarts of blood-warm water.

"The second great requirement for prevention of recurrence is general bodily exercise, performed with daily punctuality.

"The third is moderation in eating.

"The fourth is the habitual use of a sufficiency of pure water as a drink to satisfy the requirements of a body that is more than three-fourths fluid.

"The fifth includes proper clothing, and especially the substitution of linen mesh, cotton or silk of light weight for the impervious and nonporous flannel underwear so generally worn under the mistaken supposition that it is natural covering because it was first attached to the back of an animal. When the wool was on the animal it was alive and effective, but shorn and dead it must stand on a different basis as a material for human use. Laying aside all prejudices, wool is the least desirable material for either health or comfort in undergarments, winter or summer."—*New York Medical Times*, November, 1898.

W. D. CARTER, M.D.

THE KIDNEYS IN MALARIAL INFECTION.—Dr. R. G. Ricci, from numerous observations, has found malarial infection capable not only of causing albuminuria but also actual lesions, and that especially in young men in the fall and spring. The onset is insidious, and of the catarrhal, desquamative tubular form, which are easily restored to integrity in most cases. If untreated, or if the fever recur, a particularly unfavorable occurrence, the disease may assume a permanent and serious form, resembling that after scarlatina. The renal complications may appear either during or after the fever. Malarial

nephritis is often accompanied by amyloid degeneration, in which, besides the renal parenchyma, other organs are invaded: spleen and liver. Cases of malarial anasarca without albuminuria are rare. Malarial hæmoglobinuria is due to elimination of toxic substances.—*La Settimana Medica*, No. 25, 1898.

MUSCULAR NODES AS A CAUSE OF RHEUMATISM.—Dr. H. Strauss calls attention to the importance of hard fibrous nodes in the muscles of the body in some patients suffering from rheumatic pains. They may also appear in the skin or the connective tissue. Of his eight cases all were vigorous men ranging from twenty-one to forty-six years, who were not spirit-drinkers, had had no traumata nor any infections of any kind, and who, without signs of external disease, had been treated for months for rheumatism or sciatica. On examination nodes of the size of a nut, and feeling like a knotted cord in the muscles, were detected. Massage, warm baths and electricity caused the nodes to disappear. The diagnosis is by no means easy, for they must be differentiated from local muscular contractions, varices in the muscles, malignant growths, tuberculous or syphilitic processes, calcified trichinæ, etc. As to causes, some follow traumata, others are of infectious origin.—*Hospitalstidende*, No. 29, 1898.

SCARLATINIFORM EXANTHEM IN MEASLES.—Dr. Renon, of Paris, at a recent meeting of the Société Médicale des Hôpitaux of that city, related the case of a man of thirty years who presented an anomalous eruption in measles. Beginning in the face, after being preceded by an intense oculo-nasal catarrh, it was formed of a series of small points of a dark red color, a little papular, not disappearing on pressure, scattered over a bright red background, having all the characteristics of a scarlatinous eruption. Sanné regarded this as exceptional, and only as having been noted in the pre-eruptive period of measles or where it coexisted with varicella.—*La Semaine Médicale*, No. 41, 1898.—Prof. Nil Filatoff—*Semiotik und Diagnostik der Kinderkrankheiten*, Stuttgart, 1892, p. 420—speaks of confluent measles being easily confused with scarlatina. But here the eruption does not involve the entire body as scarlatina; the face, nose and lips are affected, which does not occur with scarlatina. The presence of oculo-nasal catarrh and cough point toward measles. The fever is usually higher in scarlatina.

A CASE OF SUBCUTANEOUS CRUSHING OF THE KIDNEY.—Dr. Nasse, of Berlin, presented before the Berlin Medical Society a boy of eight years, who, while exercising in a gymnasium, fell against the corner of a spring-board. Soon after he passed bright red urine. Slight improvement followed, with successive hæmaturia for five days. On account of increasing anæmia he was transferred to the hospital, where a large swelling was felt in the region of the kidney. After a few days, sudden retention of urine; and as, after catheterization, only a few drops of blood were obtained, the bladder was assumed to be filled with coagula. Simultaneous collapse urged operative interference. On cutting down onto the kidney, extraperitoneally, a large sac filled with blood was found, from which blood spurted out in a stream. The kidney was found crushed through in its middle and removed. Recovery took place in five weeks. Transient albuminuria followed. In such cases if the symptoms are not urgent one had better not interfere, as they sometimes recover spontaneously.

In a second case, where an "Einjaehriger Freiwilliger" was kicked by a horse and passed bloody urine immediately after, yet where the next day the urine was clear, though a large tumor was palpable in the region of the kidney, this tumor gradually decreased in size. Suddenly, after one month, a dark urine, like coffee-grounds, was passed, in which, together with the constituents of old blood effusion, particles of kidney-tissue were detected. At the same time the tumor disappeared. Here there was evidently a rupture of a hæmatoma.—*Muenchener Medicinische Wochenschrift*, No. 31, 1898.—

[Prof. Nasse, a prominent surgeon of Berlin, recently fell into a fissure of a glacier in the Alps and perished.]

THROMBOSIS IN CHLOROSIS.—Dr. Schweitzer, out of 243 chlorotics treated in the Medical Clinic of Zurich, has observed but 4 cases of thrombosis in this disease, and from literature he has been able to collect but 47. All of these were in females, especially at the ages of sixteen to twenty-eight, chiefly in servants, work-girls or nuns, who worked hard, with poor food and surroundings. Though usually in severe grades of anæmia, one was noted in a mild form. Fatty degeneration of the intima is at the bottom of the thrombus. Three localizations were noticed: those of the cerebral sinuses, of the veins of the lower and of the upper extremities.

SINUS THROMBOSIS.—Observed in twelve cases (twenty-four per cent.). The symptoms are serious; constant vomiting and headache, either localized or diffuse, increasing to coma. Often delirium accompanies, with a varying nervous symptom-picture. Diagnosis is very difficult. The prognosis is gloomy. Areas of softening and apoplexy generally follow.

THROMBOSIS OF THE EXTREMITIES.—This was met with thirty-seven times (74 per cent.). The lower limbs were chiefly affected; the upper only four times. The left lower limb seems to be preferably affected. Beginning usually in the peripheral veins, it radiates centrifugally and centripetally. The first signs are pain, which may become intolerable and in a few hours be followed by oedema, increasing acutely. The skin of the limb becomes pale, shining and tense. In a few days the tension is such that denting is impossible. Red and hard as well as painful cords mark the course of the thrombotic veins. In the first two weeks the fever is slight, the appetite fails, there is malaise, headache, and the local signs aggravate. In favorable cases in four to six weeks a restoration occurs. But it is not always thus; recurrences set in, the thrombus extends to neighboring veins, and emboli form and are thrown off. Embolism of the pulmonary artery has been observed seven times. From the second to the fourth week this may occur, and was always caused by movements or exertions made by the patient. The diagnosis is always easy; the prognosis is dependent upon the complications. Treatment must be absolute rest, elevation of the extremity to decrease stasis, and also with treatment of the chlorosis.—*La Settimana Medica*, No. 31, 1898.—I know of a case of chlorotic thrombosis in the lower extremity in a young female. I had two years ago a case of thrombosis of the upper extremity in an old man, with pronounced arterio-sclerosis. He recovered. The veins of the arm and hand were as hard as whip-cords.

THYROID CHLOROSIS.—Dr. L. Capitan asserts that chlorosis should only be regarded as a clinical syndrome of varying origins: nervous, gastro-intestinal,

genital, and to which he adds another, thyroid chlorosis. The patient affected with this form presents, together with the ordinary characteristics of chlorosis, but to a lesser degree, the objective signs myxœdema and Basedow's disease. These patients do not improve under the classical treatment of chlorosis, while, on the contrary, iodothylin, exclusively used, in a short time either improves or cures them after a certain time. In answer to the objection that iodothylin might be a simple stimulant to nutrition it has been noted that in ordinary chlorosis this drug is powerless.—*La Settimana Medica*, No. 31, 1898.—At a recent meeting of the Société de Biologie de Paris Dr. Camus cited a case of thyroid chlorosis in support of this theory, where a young woman after being treated with iron preparations for four years, and who, together with the symptoms of chlorosis, presented a hypertrophic thyroid, with twenty egms. a day of extract of thyroid was completely cured in one month.

PYELITIS IN ABDOMINAL TYPHUS-TYPHOID FEVER.—Dr. Eckert has observed as a complication of typhoid fever a pyelitis in three cases within a short time. A constant symptom is a sudden but short-lasting rise of temperature, with a greater quantity of pus in the urine. With the fall of temperature the pus rapidly disappeared from the urine. This complication may be one of the causes of elevation of temperature during convalescence. And as the pyelitis often goes on unnoticed, the rise may be ascribed to an error in diet, constipation, etc.—*Wratch*, No. 10, 1898.

ATHETOSIS AND TÆNIA SAGINATA.—Dr. Ruedel observed a case of athetosis in a child where, after expulsion of a tape-worm, the disease disappeared, a further proof of the truth of the views of the older practitioners with regard to reflex disturbances of the nervous system following helminthiasis.—*Deutsche Medicinische Wochenschrift*, No. 29, 1898.

EHRlich's DIAZO-REACTION IN THE URINE.—Dr. A. Krokiewicz, of Cracow, in 1105 cases of disease examined the urine 16,167 times, and arrives at the following conclusions with regard to the value of the diazo-reaction: In kidney diseases, if they do not depend on poisoning by drugs coloring the urine, the reaction is not present. In carcinoma of the stomach, œsophagus, rectum, pancreas, liver, and of the uterus, the reaction is also negative; on the contrary, in primary carcinoma of the ovary it is to be detected. In the course of tuberculosis of the lungs the presence of the reaction announces absolutely, however negative the symptoms, a rapidly fatal result. The number of the bacilli is of no importance with regard to the appearance of the reaction. Albuminuria is of no influence in the reaction in phthisis. If nephritis complicate the pulmonary affection, then the reaction will not be detected. A predisposition to pulmonary hæmorrhages lowers the prognostic value. In tuberculosis of the glands and mucous membranes particularly, the reaction is noted only occasionally. It is constant in miliary tuberculosis. In typhoid fever, even in mild forms, it is observed in the first and second weeks of the disease. As long as it is present the morbid process must not be regarded as terminated. The appearance of the diazo-reaction during convalescence nearly always points to a relapse. The writer asserts that in every case of tuberculosis of the lung and typhoid it is of decided prognostic importance.—*Wiener Klinische Wochenschrift*, No. 29, 1898.

FRANK H. PRITCHARD, M.D.

NEW MATERIAL FOR SKIN GRAFTS.—Dr. C. H. Newth reports good results from the use of thin layers of skin shaved from the hardened palm of the hand. After preparing the surface in the usual manner for skin grafting the hand is rendered aseptic and the skin grafts taken off in successive layers. They are then applied and protected in the same manner as Reverdin grafts. —*Medical World*.

THE DANGER OF CHLOROFORM ANÆSTHESIA BY GASLIGHT.—Dr. E. R. Corson writes in the *Atlanta Medical and Surgical Journal*, for October, of a case of death from this cause. A case of gunshot wound of the abdomen was operated upon under gaslight, and the decomposition of the chloroform vapor suffocated two surgeons and three nurses, one of the latter dying from the effects of it. He gives the following formulæ: $4\text{CHCl}_3 + 5\text{O}_2 = 2\text{H}_2\text{O} + 4\text{CO}_2 + 6\text{Cl}_2$. This is the reaction when oxidation is complete, and the poisonous product is pure chlorine. When the oxidation is not so complete we have a different reaction, with the formation of formaldehyde, in addition to the chlorine. This reaction may be thus represented: $4\text{CHCl}_3 + 3\text{O}_2 = 2\text{CH}_2\text{O} + 2\text{CO}_2 + 6\text{Cl}_2$.

It is at once apparent how deadly such a decomposition must be in an ordinary room with ordinary ventilation. It is evident that the illuminating gas itself was not the trouble. Any other flame would do the same.

What might have been a very serious illustration of this danger occurred not long ago at the dispensary of the Hahnemann Hospital in this city. Chloroform was given for the removal of a small tumor of the face, and the day being dark the gas was lighted. The operator, anæsthetist and nurse were all partly overcome by the deadly poisons generated, and the operation had to be discontinued.

SYMPTOMS OF HIP-JOINT DISEASE.—Dr. A. M. Phelps, of New York, in an able paper presented to the Medical Society of Virginia, says: "To conclude, the importance of symptoms, I believe, speaking generally, occur about in the following order:

- "1. Limit of motion.
- "2. Deformity, with apparent lengthening or real shortening.
- "3. Limp.
- "4. Atrophy (bone disease).
- "5. Pain in the knee (with absence of knee-joint disease).
- "6. Pain on joint pressure.
- "7. Night cries, in absence of other joint disease.
- "8. Flattening of buttock, with change in gluteal fold.
- "9. Heat.
- "10. Swelling.

"The order of these symptoms may be transposed a little by some authors, but this order will answer for diagnostic purposes." In the discussion following, Dr. Gibney called attention to the fact that hip-joint disease and hysterical spine may coexist. Other conditions, he said, from which hip-joint disease must be differentiated are: Contusions and sprains; muscular rheumatism; neuroses of the hip, infantile spinal paralysis, periarthritides, bursitis, acute synovitis, periostitis of hip; ostitis of the ilium, including sacro-iliac disease; and vertebral ostitis.—*Virginia Medical Semi-Monthly*, October 21, 1898.

W. S. BRIERLY, M.D.

USE OF THE CURETTE.—Mordecai Price, M.D., Philadelphia, says the promiscuous and indiscriminate use of the curette has been the cause of more deaths than probably any other factor in gynæcological surgery. There is no operation in gynæcological surgery that requires more knowledge of pathological conditions and a greater experience in the treatment of the diseases of women. To claim that any novice can select the proper cases for and successfully perform these operations is to deny the experience of the ablest men who have given this subject the most careful study. I will not occupy time in giving the conditions laid down for treatment by the curette, but confine myself to speaking only of those in which, in my own experience, I have found the curette of use. In endometritis it may be, at very long intervals, of use. In fungoid growths of the womb, small or large polypus, and also in the fungoid forms of supposed malignant disease, where there is great loss of blood and the patient will not submit to extirpation, the curette is of great benefit.

In abortion, miscarriage or after labor the curette has no place except in the grossly neglected cases where the woman has been allowed to go for weeks before the membranes and the placenta or parts of the placenta have been removed. All these cases should be treated promptly as soon as it is determined that the woman is aborting and the womb not able to throw off its contents. The woman should be etherized, the hand introduced into the vagina, the fingers into the womb, and every part of the membrane, placenta and clot, removed. The fingers should be used—by sense of touch you can be absolutely sure that your operation is complete, while with the curette you may scratch and scrape and wound portions of the endometrium, thus greatly aiding development of sepsis, and often the very part that should be removed is left.

In long-neglected cases the curette probably would require less violence than to attempt the removal of decomposing membranes and placenta by the fingers.—*Penna. Medical Journal*.

ANTISTREPTOCOCCIC SERUM IN PUERPERAL FEVERS.—C. E. Paddock, M.D., of Chicago, says: "To Marmorek is probably due, more than to any other investigator, the present knowledge of antistreptococcic serum. In one report he gives the history of fifteen cases of infection in puerperal women where serum was employed. In seven there was a pure streptococci infection, no mortality; in three cases of the coli communis and streptococci, all died; in five cases of pathogenic streptococcus, two deaths. Gaulard records two cases treated by Marmorek's serum—the first a rickety woman, with torn perineum, who had a prolonged labor. On the seventh day the temperature was 105°; remained steady for four days. The eleventh day temperature was the same, pulse 140. The perineal wound suppurating. Patient had diarrhœa. Curetted, packed. Twelfth day temperature was 102.7°; thirteenth day higher; case graver. Administered ten cubic centimetres Marmorek's serum into abdominal wall. Fourteenth day the temperature was lower. Recovery. The second case had a history about the same as the previous one. Patient seemed to be doing well, and an early convalescence was expected. She was seized with bilious vomiting and meteorism, vomiting became uncontrollable, and she died in thirteen days. Gaulard believes the vomiting was caused by the serum. At the autopsy there were no signs of suppuration or of peritonitis.

"Vimay treated four cases. In two cases treatment was not instituted before the twenty-fifth day. Death. Vimay believes that to be successful the treatment should be given early.

"Bar and Tissier report ten cases of streptococcus infection treated by antistreptococcic serum. Five died and five recovered. Those that ended in recovery were comparatively light.

"*Dosage.*—The amount to be given has not been definitely settled, as the serum from the different sources is not of uniform strength. At present we are obliged to rely upon the instructions which accompany each supply. In Gaulard's fatal case forty cubic centimetres of Marmorek's serum was injected in four days. Kennedy used eighty-five cubic centimetres in two days. The British Institute of Preventive Medicine fixes the initial dose at twenty cubic centimetres, followed by another twenty cubic centimetres if the temperature has not fallen (Ruffis). Bullock states that much larger doses can be given with safety. Recently the medical journals furnished numerous reports of cases treated by the serum. In 80 per cent. of these cases no bacteriological examinations were made, and in the majority of them the serum had been given as a last resort. From such cases have most of the criticisms been made, and an unfavorable report given of its use.

"It is important that the character of the infection shall be known, and to do this a bacteriological examination is imperative.

"Dr. Fry, of Washington, D. C., recently collected a report on the use of the serum from forty-six leading gynecologists and obstetricians. Thirty had no experience, eleven gave favorable results, five decidedly unfavorable. Eighty-three cases were reported—good in ten, eight negative, sixty-five doubtful.

"So far my cases have been limited, but the results have been excellent:

"*Case 1.*—Mrs. S—, aged 26, German, primipara. No bacteriological examination. I first saw her six days after delivery. Temperature 105°, pulse 120. Vaginal examination disclosed laceration in perineum and pelvic floor, lacerated cervix, uterus movable and involuting normally; lochia scant, pseudo-diphtheritic patches covering lacerations in vagina and cervix. Bichloride vaginal douche 1:3000, cleansing vagina and cervix with H₂O₂, and touching patches with silver nitrate, one drachm to one ounce. Did not enter the uterus because I was positive it was empty, and not wishing to carry any infection through the cervix into the uterus. Twelve hours later no change. Administered twenty cubic centimetres of Parke, Davis & Co.'s antistreptococcic serum. Six hours later thin watery discharge; temperature 100°, pulse 98. Twelve hours later membrane disappearing; temperature 100½°, pulse 100. Ten cubic centimetres serum administered. Twelve hours subsequent to this treatment membrane disappeared and pulse and temperature became normal. Two days following another ten cubic centimetres was injected. Quick recovery.

"*Case 2.*—Mrs. J—, aged 32, Irish, multipara. Attended by midwife. Streptococci infection. Saw her on the fifth day. Temperature 102½°, pulse 130. Vaginal examination disclosed no laceration, but a sero-sanguineous discharge, with slightly fetid odor; a thickening in region of right broad ligament. Bacteriological examination. Local and supporting treatment instituted. Twenty-four hours later temperature was 105°, pulse 120. Injection of twenty cubic centimetres of antistreptococcic serum, the local and sup-

portive treatment discontinued. Six hours later the pulse was 110, temperature 101°. Twelve hours later temperature 99°, pulse 90. Ten cubic centimetres given. Two days subsequent temperature normal; ten cubic centimetres given. Recovery uninterrupted."

From his gleanings from literature and his own experience he concludes as follows:

"1. That a bacteriological examination should be made.

"2. That the serum should be given early.

"3. That the initial dose should be larger than is usually given, namely, twenty to thirty cubic centimetres.

"4. That there are certain virulent streptococci infections wherein, no matter how strong the dose or when given, the serum will be of no avail.

"5. That the employment of the serum does not do away with the necessity of local and medicinal treatment.

"6. The benefit derived from its use in streptococci infection is demonstrable."—*Medicine*, November, 1898. WOODWARD D. CARTER, M.D.

PROTARGOL A SPECIFIC FOR BLENNORRHEAL CONJUNCTIVITIS.—Darier, A., of Paris (*Die Ophthal. Klinik.*, No. 7, 1898), considers from a very large experience with protargol that this is an antiseptic agent which produces quick and prompt healing of inflammation of the conjunctiva.

On account of protargol causing absolutely no irritation, it can be used in a 50 per cent. solution without causing any disagreeable symptoms. As a rule, the author permits patients to drop a 5 per cent. solution in the eye from two to four times daily; for local applications by the brush he uses 20 per cent. to 50 per cent. solutions once a day or every other day, according to the grade of the inflammation. For treatment of blennorrhea he cauterizes the conjunctiva twice a day with the 20 per cent solution.

If this does not suffice, he uses a 50 per cent. solution as long as the secretion remains purulent. He makes applications twice a day, and as it gets better increases the intervals. Protargol is of special benefit in those cases in which deep, wide-spreading ulcers occur. In inflammation of the lachrymal sac protargol is the best application we have, as it speedily reduces the purulent secretion, and does this without causing pain; injections may be allowed to pass into the nose without causing unpleasant symptoms. Protargol is not only a medicine for the cure of blennorrhea, but may be used as a prophylactic in a 10 to 15 per cent. solution, as is commonly done with the 2 per cent solution of the nitrate of silver.

THE USE OF HOLOCAIN IN OPHTHALMIC PRACTICE.—The writer made a large number of observations on the effects of the instillation of a few drops of a 1 per cent. solution of holocain into the normal eye. The following is a brief summary of the facts observed:

1. There is a complete anæsthesia of cornea and conjunctiva produced in from fifteen to thirty seconds after instillation.

2. The anæsthesia produced lasts about ten minutes.

3. There is immediately after instillation a slight feeling of burning, which rapidly passes off.

4. There is produced shortly after instillation a slight hyperæmia of the bulbar and palpebral conjunctiva, which rapidly passes away.

5. There is no alteration in the size of the pupil.
6. There is no disturbance of accommodation.
7. There is no alteration in the tension of the eye.
8. The corneal epithelium is not changed in the slightest, but retains its normal appearance.

In short, to put it concisely, holocain seems to have no other effect upon the eye than rendering it anæsthetic. Herein lies its advantage over cocaine, which causes a conjunctival aneurism by constriction of the vessels, dilates the pupils, and often causes a desiccation of the corneal epithelium. Another great advantage of holocain, as evidenced by these observations, is the great rapidity of its action, producing complete anæsthesia in from 15 to 30 seconds.—James M. Hinshelwood, M.D., F.F.P.S.G., Glasgow (*British Med. Jour.*, September 3, 1898).

THE PATHOLOGY OF NAPHTHALIN IN CATARACT.—In 1887 there were a number of publications concerning cataract produced by naphthalin, and recently opacity of the cornea from the effect of naphthalin has been described.

Klingmann has experimented upon a large number of rabbits, using chemically pure naphthalin in liquid paraffin (1.8), which was given the animals through an elastic catheter passed into the stomach.

One to two g. of naphthalin were given each animal every twenty-four hours. This combination did not produce intestinal catarrh or diarrhœa, and was generally well borne. Twelve hours after the administration the first effects could be seen in the lens, and in four weeks an entirely mature naphthalin cataract was produced. The animals were observed from day to day, and trial examinations made.

They generally lost in weight. In about 10 per cent. examination of the urine was made, which showed that phenol was excreted, together with blood-corpuscles and kidney epithelium, and the urine was greatly changed in character.

The affections of the lens and cornea, which have been called naphthalin cataract and corneal opacity, are secondary, and due not alone to disturbance of nutrition in the eye, but are a result in large part of general changes. The first changes are certainly observable in the eye, occurring as enlargement of the bloodvessels, hyperæmia, and extravasation of blood into the ciliary body, processes and iris. It is especially observable in albinotic rabbits after twenty-eight hours. The changes in the lens and also those in the cornea are to be described as secondary, and are to be referred to irido-cyclitis. Inflammatory changes do not alone occur in the eye, but also in the kidneys, liver, spleen and heart. Naphthalin cataract does not come on as a primary disease of the lens, and has not been observed by him to be combined with diseases of the retina, and is not alone due to hyperæmia and diseases of the blood, but also to the local inflammatory process.—Klingmann (*Archiv. f. Path. Anat. u. Phys. u. f. Klin. Med.*, Bd. 149, H. 1.)

IMPACTED CERUMEN.—For the removal of wax in the ear Dr. Ricci, of Turin, has found a solution of hydrogen dioxide acts so rapidly in disintegrating the solid cerumen that in a few minutes it can easily be removed with the use of the syringe.

WILLIAM SPENCER, M.D.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND
THERAPEUTICS.

THE INDICATIONS FOR EUCALYPTUS IN FEVERS.—Willard, of Denver, regrets the lack of definite knowledge concerning eucalyptus. He believes that its value in the common intermittents has been rather overstated by its enthusiastic admirers, and that it is in continued fevers, relapsing and typhoid, that it finds its best adaptation. In the latter, where the discharges show a tendency to excessive foulness, with high temperature, pulse accelerated, but not strong, it will change the character of the case promptly, improving the condition of the alimentary canal as regards sepsis and reducing the temperature. He believes that the action of the remedy is not merely antiseptic, but specifically curative in fevers. The provings, as given by Cowperthwaite, show that it increases the action of the heart, lowers the arterial tension, and induces a feverish state corresponding to that found in malarial, remittent and typhoid fevers. In our standard works there is no reference to the septic conditions or to the foul character of the discharges or the offensive odor. The various forms of diarrhœa and a partial list of abdominal symptoms are given, but this most characteristic feature is entirely omitted.—*Critique.*

THE TREATMENT OF NEURALGIA.—Halbert, of Chicago, in the course of the discussion concerning a case of neuralgia, asserted that he had no doubt that uric acid has much to do with neuralgia and other painful conditions which involve the nervous system. Whether it is a causative factor in typical trigeminal neuralgia is a question. He does not consider the latter disease an easy one to manage. The old method of prescribing was purely palliative, unless we except the hypodermic injections of strychnia, which are still employed with some degree of relief. He believes that in the severe cases there is a sclerosis in the Gasserian ganglion, and the pains incident to this stimulate the fulgurating pains of ataxia. The surgeons have had some success in the removal of the ganglion and nerve resection. There are two remedies which to his mind are worthy of study in this disease: these are spigelia and physostigma. The former, as we know, has a decided action upon the nerves of the face, and its symptoms of "tearing pains in the temple" is often a keynote to further indications. Dr. Lanning used a combination tablet of spigelia 2x and moschus 2x, believing that the two act in unison on both the sympathetic and motor nerves. Halbert has verified its use in several cases. Physostigma in its action upon the eye-muscles, particularly in relation to fibrillary twitchings which we see so often in trigeminal neuralgia, is often a valuable remedy. Its proving shows it to be a remedy which creates spastic conditions of the face-muscles, which we so often observe in this disease. The static spark he has also found to be a valuable adjuvant in treating these cases.

As to locomotor ataxia, while he does not doubt that the uric acid diathesis has something to do with the painful conditions in the peripheral form, he does not regard it as a factor in the genuine tabes dorsalis. There are, no doubt, many conditions in which incoördination with fulgurating pains are symptoms due to uric acid; but the true tabes, he believes, can always be traced back to primary or secondary syphilis. It is a most unfortunate disease to treat, though it can be greatly relieved by the homœopathic remedy—chloride of gold 2x (one tablet three times daily). He has found it of great value in old and obstinate cases.—*The Clinique*.

PICRIC ACID IN WRITER'S PALSY.—Halbert records the case of a stenographer who had used the typewriter for six years, together with her stenographic duties, and the index finger of the right hand had been continuously exercised. She noticed at first a weakness of the thumb and index finger, so that she could not use a pen or pencil. Finally it became difficult for her to strike the keys of the typewriter accurately, and some wrist-drop was apparent. When he first saw her the finger was quite rigid and straight, she could not bend it or use it in the least, thus showing an extreme spasticity instead of a paralysis. She had tried many doctors and all forms of massage and electricity without the slightest relief.

¹ As the patient was obliged to continue her vocation for the sake of a living, he did not offer a favorable prognosis. He commenced the use of the static current, applying the spark to the hand, arm, and the region of the cervical vertebræ. Internally he gave picric acid 3x six times daily. For a while she continued the electricity, and then he saw her no more. In two months he received a letter from her in which she said she felt she was cured. It appears that she kept getting the prescription filled at a pharmacy and took it faithfully, with the result mentioned. He was also surprised to see the improvement in her general health.

He has used this remedy very frequently in diseases of the nervous system, but never found such a perfect result in any of the palsies. This case shows that the power to rejuvenate and restore the trophism of a cell is also reflected to the fibre as well, and hence we may find it valuable in neuralgia and spasticity of these tracts.—*The Clinique*.

THE NEURASTHENIA OF PICRIC ACID.—Evans, of Chicago, in commenting on a case of writer's palsy cured by picric acid in the hands of Dr. Halbert, states that he desires to emphasize the debilitating effects of the drug upon the nervous system, centric and peripheral. This exhaustion is due either to the deteriorating effects of this drug upon the elements of the blood or to the specific changes in the nerve cells, or to both of them. The nutritive changes induced by this acid in all parts of the body are of the most pronounced character. All the functions become deranged and the victim suffers from many nameless ailments, while the vitality is reduced to such a degree that the weakened individual is prostrated by every effort, mental and physical. Many symptoms, general and local, throughout the pathogenesis are translatable from this hæmic and nervous condition.

The writer has found this drug particularly useful in girls and young women who, laboring under the prolonged strain of a multiplicity of studies in combination with the anxiety and dread of failure in their approaching examination, develop all the signs of "breaking down" and bid fair to spend

"commencement day" in bed. Such patients have no appetite, sleep lightly and lie awake, and are so fatigued when the school day is over that they drop exhausted on a lounge until they are aroused by the knowledge that there are more lessons to memorize and piano practice to worry about. Languor and fatigue attend on even a short walk, and twitchings of the muscles take place both when she is awake and asleep. A hysteric state presents itself, and will power is lacking except under the stimulus of necessity. Headache, more or less constant, may be either frontal or occipital, and the menses are irregular. Such cases are usually considered to be subjects for the various salts of iron, and many are also fed on some combination of beef, wine and iron for weeks and weeks together, the slight benefit derived from their use in no way impairing a misplaced confidence in them.

These patients he has found by experience to be materially benefited by the use of picric acid, which covers the whole field of cellular changes in the blood and nerve-centres. He does not mean that this drug is a specific for all such cases, for phos. acid, silica, nux vom., etc., all have claims in this direction.

Neither will it be the all-sufficient remedy in these neurasthenias when other diseases are present. But in the uncomplicated cases such as he has described he has been able, in a large number of instances, to afford relief by the use of picric acid.—*The Clinique*.

MELILOTUS IN NERVOUS HEADACHE.—According to Halbert, most of the headaches which partake of a nervous character are located either in the vertex or the occipital region of the head; these are due to the constant afferent irritations which disturb the motor-brain and medulla reflexly. There is, however, a nervous headache due to sympathetic irritation, and hence related to gastric and alimentary involvement. The disturbance, however, is not always due primarily to digestive disorders; these conditions are rather secondary to general neurasthenic weakness in which gastric and alimentary crises are attending features. Such a status, long continued, irritates and perverts the vasomotor system until cerebral congestion is quite pronounced. One of the features of such cases is the periodicity of the headache, representing thus a cumulative irritation of the general nervous system. He has found in cases of this kind that melilotus is a remedy of unusual value, as a case cured by the third decimal and reported at length fully proves.—*The Clinique*.

SABADILLA.—According to Kent, sabadilla resembles lachesis in the fact that it goes from left to right, but differs from lachesis in that it is a cold patient, sensitive to cold atmosphere, cold room, cold food, etc. Wants to be well wrapped up; hot drinks to warm up the stomach; sensitive to catarrhal condition which wants hot air. Sabadilla is very sensitive to odors and exposure, is liable to rose cold in June and hay fever in August. It is always ameliorated by heat.—*Journal of Homœopathics*.

EQUISETUM IN ENURESIS.—Foulon, of St. Louis, remarks that equisetum hyem. seems to owe its therapeutic virtues to its contained silicea. Erethistic weakness seems to run through its entire symptomatology, and it is apparently most useful in neurotic, scrofulous children. It may also be useful in cases complicated with a chronic cystitis—the urine containing blood and albumin.—*Clin. Reporter*.

F. MORTIMER LAWRENCE, M.D.

THE RENAL LESIONS OF SULPHONAL.—Dr. Ernest Nyssens, of Brussels, warns against the use of sulfonal as a hypnotic, for (according to a recent German writer it is a true blood-poison) it has decided inconveniences and should be abandoned, as has been done in Germany. There are anorexia, vomiting, constipation, regurgitation of food and pains in the epigastrium. There are also headache and psychic depression. As to the kidneys themselves, there are scanty urine, albuminuria and hæmatoporphynuria, and in the urine one finds renal epithelium and red blood-corpuscles. There are profound morphological alterations of the kidneys. Dr. Naberkoff, of St. Petersburg, from experiments on animals, has found in the kidneys granular and fatty degeneration of the renal epithelium, disseminated areas of necrosis, desquamation of epithelium, formation of epithelial, blood, granular and hyaline casts. In cases of long poisoning there was infiltration of the capsules with formation of new connective tissue around them, in the capsules and between the tubes. At times it was noted that this tissue crowded out the urinary canaliculi, which became empty. The inflammation was especially hæmorrhagic. In the acute cases the intra-renal hæmorrhages were more pronounced than in the chronic ones. The heart itself presented albuminous and fatty degeneration, with lesions of segmentary myocarditis.—*Journal Belge d'Homœopathie*, vol. iv., No. 4, 1898.

PULSATILLA AND ITS CHARACTERISTICS.—Headache from overloading the stomach with fat foods. A dull migraine, which is worse on going to bed. A purulent conjunctivitis with a thick, yellowish and mucous discharge which causes the eyes to stick together. Styes on the eyes. Neuralgia, which is worse in the evening and during the night. A catarrhal state of the stomach, with a white-coated tongue, and a disagreeable, bitter taste in the mouth. Chronic catarrh of the stomach and cardialgia in chlorotic girls and pregnant women. Heartburn and a disgust for warm food. Colic and diarrhœa, especially in the evening after eating or in the night. Intestinal catarrh, with evacuation of white, slimy passages. Pain on urinating and involuntary passage of urine at nights. Irregular menstruation. The menses are either absent altogether or appear late. At the same time there may be a great deal of leucorrhœa, which greatly weakens. Dyspnœa, palpitation of the heart on going up stairs, sleepiness and languidness in the morning, with a pale face, and, in short, those symptoms which appear in chlorotic and anæmic girls. Pulsatilla may be given with good results in epidemic measles where there is a cough, with expectoration of a yellowish mucus, as well as in certain forms of subacute rheumatism, where the pains jump from one joint to the other. In the affections of pregnancy it holds an important place. The pains and symptoms are aggravated in the evening, in bed, by rest and warmth. They are ameliorated by slowly moving about (ferr.) and fresh air. Restless sleep, with a tendency to uncover. The second or the third dec. dilutions, taken in the morning, act best in acute cases. In chronic cases one might try higher ones.—*Homœopatisch Maandblad*, No. 9, 1898.

THE TONGUE SYMPTOMS OF SEVERAL IMPORTANT REMEDIES.—Dr. Dahlke, of Berlin, has arranged the tongue symptoms of the different drugs in a handy repertory. We select a few.

Apis.—Tongue fiery red, dry, covered with vesicles; it is protruded tremulously and catches on the teeth. The edges and tip red and vesiculous. Feels as if scalded. Swollen in diphtheria.

Arnica.—Tongue dry and with a brown stripe down the middle (typhoid). Yellowish coated (dyspepsia).

Arsenic.—Tongue raw, red and excoriated; dry; tongue with sordes and a dark-brownish coat (typhoid). Mapped tongue (acute malady).

Baptisia.—Tongue with a brown stripe in the centre, the margins red and shining. Tongue brown, dry (typhoid).

Belladonna.—Tongue dry, tip and edges red, the middle white. Papillæ erect and enlarged (strawberry tongue, scarlatina). Tremulousness.

Borax.—Aphthæ on the tongue.

Bryonia.—Tongue white or yellowish-white; in typhoid the middle especially white, the margins free. Dry and fissured tongue (typhoid).

Camphora.—Cold tongue (cholera).

Chelidonium.—Tongue yellowish coated, with imprints of the teeth (liver affection).

China.—Tongue heavily coated, white, yellow, dirty.

Colchicum.—Tongue coated a dirty brown; or, bright red, with a coating at the base.

Gelsemium.—Tongue as if paralyzed (dulc.).

Hydrastis.—Tongue broad, soft, slimy; swollen, showing imprints of the teeth; a dirty yellowish coat. It feels as if scalded.

Hioscyamus.—Tongue dry, red and fissured (bell.), with a brownish coating.

Iodium.—Two coat stripes of mucus or foam down the tongue (pancreatic affection).

Kali bichrom.—Tongue thick, broad, yellowish-brown or smooth, red and shining. Edges full of painful ulcers. A sensation as if a hair were on the root of the tongue.

Mercurius.—Tongue moist, soft, flabby, spongy, swollen, with imprints of the teeth. Sore and ulcerated tongue. Coated a dirt-yellow.

Merc. iodat.—Base of tongue a dirty thick yellow coating, the fore part being clean and red (diphtheria).

Phytolacca.—The tip very red, sensitive; vesicles on the edges. Pain in the root of the tongue on swallowing. The Eclectics assert that the tongue of this remedy is smooth, slick, somewhat lead-colored, and appearing as if coated with some glutinous material, especially in epidemic diseases.

Pulsatilla.—Tongue coated a grayish-white.

Rhus toxicod.—Tongue dry, as if singed, brown, with a triangular and red tip spot at the tip. Tongue of a dark-brown, fissured and bleeding. Tongue smooth and red (scarlatina).

Stramonium.—Tongue red or whitish, and covered with fine red points. Coated yellowish-brown, dry, fissured, especially in the middle (typhoid).

Sulphur.—Tongue white, with a red tip and borders (acute affection). Tongue dry, with a red tip; difficult speech (typhoid pneumonia).

Terebinthina.—Tongue dry, red, glistening (typhoid and peritonitis). Tongue smooth, as though it had been scraped of its papillæ.

Veratrum viride.—A bright red stripe through the middle of the tongue (fever, meningitis). — *Zeitschrift des Berliner Vereines Homœopathischer Aerzte*, Bd. xvii., Hft. 11, 1898.

PHOSPHORUS IN INSOMNIA.—Dr. Rischer, in a case of albuminuria in a merchant of fifty years, with chronic nephritis and cyclic appearance of albu-

minuria, who suffered from absolute insomnia, and who had received all the different old-school hypnotics and narcotics from morphine to the latest addition, trional, phosphorus 4x, a few drops during the day, brought about a refreshing sleep.—*Leipziger Populäre Zeitschrift f. Homœopathie*, Nos. 11 and 12, 1898.

CASES FROM PRACTICE.—Dr. Oscar Hansen, of Copenhagen, relates a case of *eczema of the fingers* which was cured by ars. 3x three times a day; *urticaria* cured by calc. sulph. 3x, after apis, sepia and sulph. had been used unsuccessfully; *eczema of the scalp, with swelling of the cervical and sub-maxillary glands*, cured by merc. precip. ruber 2x three times a day and local application, morning and evening, of an ointment of the red precipitate, one part to forty of lard. A *syphilitic eruption, with nasal catarrh*, in an infant of six weeks, with a syphilitic father, cured by merc. iod. ruber 2x, three times a day. *Scrofulous adenitis*, emaciation, palpitation of the heart, dyspnoea, were speedily removed by the use of iodium 2 c. dil., five drops three times a day.—*Journal Belge d'Homœopathie*, No. 2, vol. v., 1898.

TYPHO-GRIPPE AND ITS TREATMENT.—Dr. Pinart, of Barcelona, Spain, has observed a form of gripe with admixture of typhoid symptoms in that city quite frequently recently. He employed, with success, the dried blood of animals which had been immunized against the disease, and in the form of rectal injections. Certain homœopathic remedies, as bell., bry., acid. cyanhydr., mephitis putorius, apis, phos., have also given him excellent results.—*Revista Medica de Barcelona*, No. 1, 1898.

CHINIUM SULPHURICUM IN PERIODIC PAINS.—Dr. Leopold Grossberger, in intermittent neuralgias with a definite periodicity, in the past seven years of his practice has found the sulphate of quinine 1x the best remedy, a specific of the first order. He gives it for three or four days, in the intervals free from pain. Arsen. alb. 5-6x is stated to be indicated in these periodical seizures. He cannot confirm this. In pronounced malarial fever he administers the drug only in the first dec. trit., and he is satisfied with his results. The remedy should not have been taken in massive doses previously. In malarial affections in little children in this dose it acts well. In many cases of headache, beginning at a definite hour and disappearing at a certain hour, chinium sulph. acts unfailingly.

In a case of very violent sciatica, which had lasted for four years, and which appeared at nine in the evening daily, in a woman of forty, a widow, with a tendency to anæmia and obesity, this remedy, in one single dose, caused the pain to vanish. It did not recur; she took the drug for some time as a precautionary measure. The cure was lasting.—*Leipziger Populäre Zeitschrift fuer Homœopathie*, Nos. 13 and 14, 1898.

IRIS VERSICOLOR IN MIGRAINE.—Dr. Juan Arriaga advises iris vers. in hæmicrania when there are nausea and vomiting, intense pain in the head, pulsation in the temples, the pain and beating being more pronounced on the left side. When the patient searches out a dark place, though there is no actual photophobia, and yet she desires to rest, then iris is an excellent remedy. A few doses of the drug every morning before eating will soon remove the disease definitely.—*La Homœopatía de Mexico*.

FRANK H. PRITCHARD, M.D.

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QUEBRACHO.

BY EDWIN M. HALE, M.D., CHICAGO, ILL.

THE botanical name of this tree is *Aspidosperma quebracho, blanco*. Its principal habitat is Brazil and the Argentine Republic, but it probably grows in Bolivia and Paraguay. It is a beautiful evergreen tree, belonging to the Apocynaceæ. It flowers from November to January. It attains a height of 13 to 14 metres (40 to 45 feet) in the dry regions, where it is especially abundant. In the damp, tropical regions it often attains a height of 20 or 30 metres, nearly 100 feet. The diameter of the trunk is often 4 or 5 feet. The leaves are a light and shining green. The flowers are yellow.

The part of the tree used in medicine is the bark. The wood possesses similar properties, but in a much less degree. Quebracho bark contains at least six different alkaloids. The one named *quebrachin* is said to be the most powerful, and to represent its chief medicinal properties. This is rarely used in medicine.

Official Preparations.—*Aspidospermine* of commerce, and the drug generally prescribed, consists of *all the alkaloids of the bark*. This is prepared for use by trituration with sugar of milk in $\frac{1}{10}$ th and $\frac{1}{100}$ th per cent. (1x and 2x trit.)

Tincture of the bark, made with dilute alcohol. (A tincture is made from the wood, but is weaker than if made from the bark.)

Fluid extract and solid extract.

Dose.—The regular school give $\frac{1}{4}$ to $\frac{1}{2}$ grain of aspidospermine; 15 to 60 minims of the fluid extract; 1 to 3 grains of the solid extract.

If quebrachin really represents all the medicinal properties of the drug, it ought to be used instead of the combined alkaloids, but I cannot find that it has been used, in this country at least.

Merck's quebrachine is sold at the enormous price of \$3.50 for 15 grains; his aspidospermine ("amorphous, pure") at 75 cents for 15 grains. This latter is the alkaloid I have generally used. I have not found it useful above the 2x trituration, and in most cases the 1x is required. It is best given in tablets, each containing $\frac{1}{10}$ grain. The tincture acts well in 5- to 10-drop doses. I have found pills of the solid extract, 1 grain, act very well, one every three hours.

Toxic and Physiological Action.—"Experiments upon *frogs* gave complete motor paralysis of central origin, with paralysis of the respiratory organs, and diminished frequency of the heart-beats, from 54 to 60 pulsations down to 8 or 10. This latter action was not caused by irritation of the vagus."

"With *rabbits*, its use hypodermically was followed by paresis of the extremities and difficulty of breathing. Toxic doses caused death, preceded by paralysis of the voluntary movements, great dyspnœa, and terminal convulsions. Breathing was deepened and retarded."

"In a healthy *dog* dyspnœa was caused, with increased frequency of heart-beat and salivation. The temperature of the body was not perceptibly influenced."

In *man*, healthy as well as feverish (phthisis, pleuritis), it had no influence on the temperature or on the frequency of the pulse. In one case it caused "great weakness in the legs at night." In large doses it has caused nausea, vomiting, headache, partial unconsciousness, dizziness and salivation. It is asserted that in medicinal doses "its prolonged administration produces no alteration in any organ or function." But there have been no systematic provings, and it is highly probable that

many valuable pathogenetic symptoms would be caused in other than the respiratory organs.

"There is no mention made of quebracho causing dyspnœa in men. It may not be able to cause real dyspnœa at all, but only that condition designated as *apnœa*, which name, once applied to dyspnœa, is employed now only in its physiological sense to denote the condition in which the blood is too highly oxygenized. The presence of an over-abundance of oxygen prevents stimulation of the medullary respiratory centre, and respiration is arrested in consequence."

Penzold, commenting on its effects on animals, says: "Care in the administration of this drug is to be recommended," *i.e.*, too large doses should be avoided, lest we produce apnœa. His theory, which has been corroborated by experience, is that the drug "might, by its direct influence, enable the blood to take up more than the usual supply of oxygen, so that the blood flows with a lighter red color than usual through the capillaries into the veins."

A case is narrated by Dr. Rohne where "the *acne nose* of an emphysematous patient, which usually had a violet-blue color, changed to a fiery red under the use of quebracho."

Other instances are noted where the face became "flushed red" when taking it. Penzold's theory, therefore, may be correct.

But if that is an explanation of its action in causing apnœa, quebracho is not homœopathic to the dyspnœa which it relieves and often cures. It can only be homœopathic to apnœa, and, as yet, no clinical records have been published relating to its use in that condition.

The question arises: How does quebracho relieve dyspnœa? The consensus of opinion is that it acts (1) by stimulating the respiratory centres; (2) by increasing the oxygen in the blood.

"The respiratory centres are stimulated by a venous state of the blood. As the venosity increases above the normal the activity of the respiratory centre increases, the respiration becoming deeper and quicker, and the accessory respiratory muscles are thrown into action. This condition is called *dyspnœa*. The excessive venosity of the blood paralyzes the nerve centres; but if the blood be aërated by artificial respiration normal

respiration is resumed. Now, in most cases of dyspnœa the blood is too venous."

Does quebracho relieve by decreasing the venosity, and how? In toxic doses, according to Brunton, it *paralyzes the respiratory centres and the heart*. Yet in medicinal doses it does just the contrary. How else can it act, then, than according to the law of similia? Now we know that over-stimulation of the nerve centres anywhere results in their paralysis. Dyspnœa, then, is really a secondary action of quebracho. This is why minute doses of this remedy will rarely be found useful, for symptoms like its primary ones are rarely observed in disease.

Just here it may be appropriate to quote the opinion of several European authorities relating to its physiological, toxic and curative action. (1) "*El Sentido Catol*" claims: 1. Quebracho diminishes the frequency of the respirations and cardiac contractions. 2. It strengthens and regulates cardiac contractions, either directly or through the nervous system. 3. This action is evident and immediate. 4. It has a manifest anti-dyspnœic action. 5. In nervous dyspnœas it must be tried in a greater number of cases. 6. It produces the same effect in dyspnœa from acute pulmonary affections. 7. Its prolonged administration produces no alteration in other organs or functions.

Dr. Don Juan Mauriel Mauriel Larrion, physician to the Hospital de la Princesse de Madrid, has employed quebracho in a number of diseases of the respiratory and circulatory organs, administered in the form of a syrup, a hydro-alcoholic tincture, and an extract in doses of 50 centigrammes, to 4 grammes of the two latter preparations. The following conclusions are a short *résumé* of the author's observations:

1. The principal action of this drug is to cause a diminution of the number of pulse-beats per minute, and lessen the frequency of the respiratory act.

2. Its principal and direct action is on the circulatory centre, giving tone and regularity to the contractions, with an intermediate effect on the nervous system.

3. This action is rapid, and is manifested almost immediately after the administration of the medicament.

4. It is not employed with such effect in nervous dyspnœa.

5. It is possible to produce the same effect in diseases of the thoracic organs when they are due to malaria.

6. Its administration in the doses indicated is not dangerous, and its continuation will not have a bad effect on other organs.

At the Medical Clinic in Jena, Prof. Maragliano made some observations on the action of aspidospermin and quebrachin, both alkaloids of quebracho. These preparations have the property of reducing the number of respirations, but only when the disturbance, or cause of the disturbance, is functional; if there are organic changes causing the increased respiratory movements, then neither of the preparations are of any real value. After the use of these drugs the pulse-beat sinks rapidly, in fact, the healthy pulse can be brought down to 20 per minute, while the blood pressure, as tested with Basch's apparatus, is not affected in any manner. The physiological action is marked. Administered by the mouth, the effects commence in about 30 to 40 minutes; hypodermically, in from 5 to 10 minutes. The alcoholic doses may be given in 10-gramme doses, using some pleasant vehicle. The doses of the alkaloids range from 5 to 25 centigrammes per day. Large doses may cause vomiting. In a solution of 5 centigrammes to 1 gramme of water, it may be injected hypodermically without causing any local affection whatever. In asthmatic attacks the subcutaneous use is the more preferable.

At the recent meeting of the French Association for the Advancement of Science at Blois, a paper was presented by Drs. Huchard and Eloy on this subject. "There are many alkaloids of this drug, no less than six having been already isolated. Numerous experiments having demonstrated the antipyretic action of these alkaloids, the authors were led to make a trial of them in the human subject. In a certain number of patients with typhoid fever, to whom quinine had been without effect, a notable reduction of temperature was obtained by the hypodermic injection of the muriate of aspidospermine in doses of one and a half to three grains. This latter amount should never be exceeded. The authors noted especially the rapid reduction of temperature following the exhibition of these several alkaloids, and also remarked upon the changes occurring in the blood after their administration. The blood is changed in color in a way very similar to what occurs after poisoning by carbonic oxide."

Clinical Reports.—I have selected from various sources the

following clinical cases illustrating the palliative and curative effects, also some failures, in order that both sides may be seen.

Report 1.—Dr. F. Rohne, of Zurich, Switzerland, reports the most brilliant results were obtained in the asthmatic attacks of consumption. After the use of two teaspoonfuls of quebracho solution, the respiration sank in one and three-quarter hours, from 54 to 27 or 30. During the following night the patient slept well, which previously was impossible. In exudative pleuritis reduction was more marked, falling from 26 to 28, 24 to 22. In asthma of emphysematous patients (three) it fell from 32 to 36, to 32 to 18. The respirations did not change much in complications of emphysema with pleurisy—26 to 30 and 24 to 20 respirations; once from 24 to 16 respirations. In the latter case a superficial respiration was observed at times. In a similar case, without respiratory change (18 to 19 per minute), after exhibiting the remedy it required close observation to count the respirations; and the sharp (at times distinctly heard at a distance) whistling sound becomes markedly weaker. Marked cyanosis in phthisis, emphysema, etc., was either lessened or entirely relieved by quebracho. It also apparently had some influence in a case of “colossal” cyanosis resulting from a congenital pulmonary and chronic pneumonia. The “acne nose” of an emphysematous patient, which usually had a violet-blue color, changed to a fiery red under quebracho, and was much admired by a room-mate. Subjectively, patients, without exception, breath more or less easy, and in some cases an extraordinarily easy respiration follows. In a case of thrombosis of the pulmonary artery, a respiratory reduction from 37 to 28 respirations per minute, from 54 to 34 respirations, and from 46 to 39 respirations, followed, after an exhibition of each teaspoonful, respectively, of quebracho solution, with diminished cyanosis and greater comfort. There was no prejudicial concomitant appearance nor narcotic action whatever. There was usually, first, a feeling of warmth in the head. The disposition to cough is lessened, and the expectoration is expedited. Sometimes there is some perspiration, frequently slight salivation. The medicine does not taste unpleasantly, is astringent and aromatic.

Report 2.—Dr. J. A. McCreery reports :

CASE 1.—Mrs. G., 40 years of age. Palpitation and shortness of breath on going upstairs, for two years. Loud mitral regurgitant murmur. Pulse irregular and weak. Dyspnœa great on the least exertion. Ordered fluid-extract of quebracho, $\mathfrak{m}\mathfrak{x}$ xxx, t. i. d. No appreciable benefit after about \mathfrak{z} ss had been taken.

CASE 2.—Mrs. L., 67 years of age. Has had two attacks of bronchitis with asthma. During last three weeks had had severe cough, and for ten days respiration difficult, especially at night. For a week has not been able to lie down. Hoffmann's anodyne and morphine gave only partial relief. Pulse 112. Râles over both lungs; prolonged expiration. Ordered fluid extract of quebracho, $\mathfrak{m}\mathfrak{x}$ xxx, whenever breathing got bad. First dose gave almost complete relief for two hours. Took the drug for three nights, always relieving her so that she was able to lie down and sleep.

3. Woman, 70 years of age, suffering from an exacerbation of an old chronic bronchitis. Breathing short and labored; orthopnœa at night. Expiration prolonged. Quebracho gave great relief, enabling her to lie down and sleep. She required one or two doses every night.

4. Dr. Simon details six different cases in which he administered quebracho successfully.

He concludes his report with the following observations:

1. Quebracho is a substance possessing the property of moderating respiratory movements; it acts, in truth, as the digitalis of the lungs.

2. It relieves dyspnœa, whether resulting from purely nervous disorders, or when due to anatomical alterations in the respiratory or circulatory apparatus.

3. Its action is immediate and its effects safe, at least so far as observed.

4. Its effects on dyspnœa caused by circulatory troubles warrant the belief that it not only acts directly on the nervous system governing the respiratory movements, but that its influence extends over cardiac innervation.

5. Finally, it is believed that quebracho facilitates expectoration.

CASE 5.—W. S. Gottheil, M.D., House Physician Second Medical Division, New York Charity Hospital, reports the employment of quebracho as follows: "For cough and difficult breathing in phthisis, third stage, \mathfrak{z} ij, t. d., with good results; dyspnœa in a case of Bright's disease, \mathfrak{z} ss, t. d., with great improvement; dyspnœa in phthisis, \mathfrak{z} j, t. d., with considerable benefit; \mathfrak{z} j, t. i. d., in asthma and bronchitis with good results."

CASE 6.—The patient, a man 65 years of age, was given the tincture in teaspoonful doses, repeated every hour, and at the

end of the first hour the breathing was reduced in frequency from 64 to 60 respirations, in the third hour to 30, and decided decrease of the symptoms, with complete recovery, the next day. The remedy has been administered in fourteen other cases, in which, with few exceptions, it acted as a palliative. In one instance, where the patient had for years suffered from emphysema of the lungs, great improvement was noticed; likewise in a case of dyspnœa in a woman of 60, and in two cases of fatty degeneration of the heart, patients aged respectively 72 and 68. In the case of a 72-year-old lady who was affected with pleuritic exudation, and also in a case of chronic catarrh of the lungs, no benefit was received. In six cases of phthisis, only two were noticeably relieved after administration of the remedy. No derangement of normal conditions was observed to be due to the remedy. The author also speaks very highly of the spirituous extract of quebracho as a remedy for diarrhœa. (A. Berthold, M.D.)

CASE 7.—The cases treated with this remedy were two of hypertrophy of the heart in the last stages, with dropsical exudation into the cavities, general œdema, violent dyspnœa and extreme weakness; three cases of Bright's disease, succeeding scarlet fever; one case of tuberculosis with œdematous dyspnœa, and one case of pleuritic pain with serous exudation of the pleura and violent dyspnœa. In all these cases 5 grammes extract of quebracho aquosum in 20 grammes water were given; dose, a tablespoonful every three hours; and the promptness of its action in controlling the respiration was indeed so uniform and elegant that I am constrained to recommend its further use. Although tuberculosis and weakness of the heart cannot be cured by its use, still the relief afforded the patient is a gratification to the practitioner. (Dr. J. Krauth.)

CASE 8.—In a case of mitral incompetence and stenosis, quebracho relieved the severe nocturnal dyspnœa most decidedly. In a case of fatty degeneration of the heart it gave great relief, but had no influence on the œdema, which digitalis removed. One of the most interesting cases in which I have used quebracho was that of a man aged 65, weighing 250 pounds. He had fatty degeneration of the heart, emphysema of the lungs, and angina pectoris. He had not been able to leave his chair for several weeks; the dyspnœa was so great that he could not move even a few steps without great discomfort; he had agonizing angina several times a day and often in the night, and heart failure seemed imminent any hour. Two grains of quebracho given every three hours had a very happy effect, enabling him to walk about the house, but as the attacks of angina at night were just as bad, 4 drops of a $\frac{1}{100}$ solution of glonoin (nitro-glycerin) was given at bedtime, which prevented their return. (Dr. E. M. Hale.)

I have reason to believe that the alkaloid has a better action than the fluid or solid extract. The dose required is so small that when triturated with sugar of milk, even children readily take it. Even in as small doses as the $\frac{1}{100}$ of a grain it acts promptly in the asthma of Millar, and palliates the distressing breathing of spasmodic croup.

CASE 9.—“Mrs. L. W., aged 48, mother of five children, had been in bad health for several years, and in the fall of last year (1886) she began to suffer from ascites. During the past winter she would have frequent attacks of dyspnoea due to the dropsical accumulation in the abdominal cavity, which finally became so severe as to seriously alarm her friends. All the usual remedies had been tried, with little or no benefit, by the practitioner who had charge of the case, and at his suggestion I was called in consultation. In connection with treatment for relief of her general condition she was put upon the solid extract of quebracho in 2-grain doses for the relief of the dyspnoea, given at the time an attack was threatened, and repeated as often as was indicated, with the results of almost complete relief from this most distressing symptom.

“The sample I had obtained was soon exhausted, when I ordered a fresh supply, as the patient was enthusiastic in its praise, declaring it was ‘worth its weight in gold.’ Its use was continued in this case until the cause which produced the symptom for which it was given was removed by appropriate treatment, and she is now fully restored to health. Its action in this, the first case in which I had used the drug, was remarkable; the difficulty of breathing was at times so great as to be alarming, when two grains of the solid extract was sufficient to give almost immediate relief, without any bad effects whatever. It had no action on the pulse in this case, except to render it a little more full without affecting the rate.” (Dr. W. P. Ellis.)

CASE 10.—“A negro man, of more than ordinary intelligence for one of his race, forty years of age, and by occupation a farmer, has been a sufferer from bronchial catarrh, with emphysema, for the past two or three years. He is able to walk about, but the least exertion gives rise to a difficulty of breathing which is very distressing. He had been under my care about eighteen months before I obtained the quebracho, and no remedy that had been administered had been capable of preventing or cutting short the attacks of dyspnoea. Upon the occasion of his first visit to my office after I had obtained the drug I gave him the entire sample of the fluid extract, about one ounce, with instructions to take a teaspoonful whenever he felt the difficult respiration, and also to take a dose just before undertaking any of the small tasks which had previously given rise to an attack. Several days subsequently he returned for a

fresh supply, saying that it had acted like a 'charm,' and that with it he was able to walk about his small farm and attend to its management without experiencing to any great degree the ill-effects which had previously followed the slightest exertion. He seemed greatly disappointed upon hearing he had exhausted the supply on hand, but this feeling was somewhat mitigated when he was informed that I would give him the same drug in a different form. I accordingly gave him a lot of gelatin capsules, each containing two grains of the solid extract, and instructed him to use them in the same way—*i.e.*, to take one capsule whenever an attack of dyspnœa was threatened, and also to take one just before engaging in work of any sort. He has now been taking it perhaps six months, and, while his general condition is not much changed for the better, by taking the quebracho as directed he is enabled to prevent or cut short the attacks which had, previous to his beginning its use, made his life a burden to him." (*Ib.*)

CASE 11.—"Blonde lady, about eighteen years of age. Mother and two sisters had died from phthisis. I do not think I ever saw such difficult breathing; it almost amounted to asphyxia. I prescribed fld. ext. quebracho in 20-gtt. doses, to be repeated every two hours until relief occurred. She very rarely had to repeat this, the first dose giving prompt relief, and she would continue to breathe well for twenty-four hours without its repetition." (J. P. Baird, M.D.)

CASE 12.—An old man, who gave a history of cough with white and yellow expectoration, and dyspnœa increased by exertion, dating back several years. For the past two years he had suffered from sudden attacks of dyspnœa, occurring at first at night only, but lately becoming so frequent as to distress him during the day. During the past winter his cough increased in severity, and the dyspnœa became so constant as to prevent his working. He complained of irregular paroxysms of dyspnœa, accompanied by wheezing sounds. He had become emaciated, had a poor appetite, imperfect digestion and bowels irregular. There is general venous congestion of the surface. The chest was barrel-shaped; percussion indicates emphysema, and on auscultation evidences of bronchitis as well are found, sonorous, sibilant and mucous râles being heard over the upper part of both lungs; heart sounds normal. The patient is suffering from dyspnœa, his respiration being rapid and labored; urinary examination being negative. He was put upon ʒss of fluid extract of quebracho every four hours. During the following week the dyspnœa was gradually relieved, so that at the end of seven days the patient did not suffer from it at all while at rest. The improvement was very marked during the first two days. The patient had three attacks of asthma at night

during the first week under treatment. Each attack was promptly relieved by the drug, each succeeding attack being less severe than the one preceding it. During the second week of treatment there was but one slight paroxysm of dyspnœa, and the constant shortness of breath had entirely disappeared. During this time the dose was decreased to $\text{m}\ddot{x}$ xxx, t. i. d. At the end of fifteen days he had gained flesh and strength; his cough had become less distressing under appropriate treatment, and, as dyspnœa disappeared, he returned to work. (*Ib.*)

CASE 13.—Mrs. M. had been a sufferer from valvular disease of the heart for some ten years. She has been suffering with dyspnœa, almost day and night, for the last three years. She had become so prostrated that she had not left her room for more than six months, and has existed with the minimum amount of sleep during that time. Some four weeks ago I concluded to try quebracho. Since commencing its use I have been administering it in doses of a half teaspoonful three times a day, and the result has been almost entire relief of the dyspnœa, and she is now able to sit up all day, has gained in flesh every day, and reports herself as feeling like a new being. I need not say that in this case all the old remedies had been tried in vain. (W. T. Mahon, M.D.)

CASE 14.—In a case of convulsive asthma the respirations sank within three hours from 64 to 30, after exhibiting three teaspoonfuls of the tincture of the wood of quebracho. The dyspnœa was caused by pulmonary emphysema, insufficiency, and stenosis of the mitral valves, fatty cardiac degeneration, dilatation of the right ventricle. (The author states that in case of irregular pulsations, when digitalis has been used, this remedy must be discontinued.) If orthopnœa persists, quebracho is a desirable remedy, and the intensity of the attacks becomes decidedly weaker than before. Out of six cases of phthisis only two were successfully treated for difficult breathing with quebracho (wood). In one of these cases the respiratory frequency fell from 62 to 28 after the second hourly teaspoonful of tincture of quebracho. (Dr. Berthold, of Dresden.)

CASE 15.—Male 38. Bronchitis (emphysema and asthma, the latter being almost entirely paroxysmal and the paroxysm being of extreme severity). On three occasions quebracho was given in ss doses every half-hour for two hours without the slightest benefit. Nearly the whole list of antispasmodics was gone through with, and nothing but morphia was found to do any good. (*Ib.*)

CASE 16.—Male, 54. Bronchitis, emphysema and asthma. Paroxysms marked, but less severe than in the case just related. Two ss doses, given at bedtime, gave him complete relief, which lasted all night. This was repeated a number of times, always with the same result. (Dr. L. E. Holt.)

CASE 17.—Under the same roof with me is a lady who is a patient of as good a physician as the city affords. She has a chronic eruptive disease at times, involving her throat and possibly her lungs. No tubercles. She is affectionate in disposition, but impulsive and at times violently manifests displeasure. In such paroxysms she always has dyspnœa, formerly to the extent of occasioning blueness of the lips. Now she calls on my daughter for a dose of fluid extract of quebracho. Before she knew of this agent she suffered almost constantly. Now she says half a teaspoonful will give relief very soon and enable her to meet and entertain company and contend with the boys—her children—throughout the day. (Dr. Frank A. Ramsey.)

CASE 18.—Dr. Penzoldt's discovery that various forms of dyspnœa can be alleviated by quebracho bark receives confirmation from Dr. Berthold, of Dresden, and Dr. Picot, of Carlsruhe. By both, Penzoldt's extract was rigidly adhered to. Dr. Berthold relates two cases of spasmodic asthma which were much benefited by the new drug. In the first the respiration fell after three doses from 64 to 30, with general improvement of the symptoms; in the second, where the asthma depended on emphysema, the effect was less rapidly produced; but the patient, who had been under Dr. Berthold's care for four years, and who generally had to lay up for one or two weeks at the time of his attacks, was about again in five days. In a case of mitral incompetence and stenosis quebracho relieved the severe nocturnal dyspnœa most decidedly; in two advanced cases of fatty degeneration of the heart it also did good, but digitalis had to be given for the relief of œdema, over which the quebracho exerted no influence whatever.

Dr. Berthold, however, from his small experience is inclined to regard the latter drug as indicated in cardiac disease when the pulse becomes irregular under the action of digitalis, and when orthopnœa continues after the digitalis has been omitted. In one or two cases of chronic bronchitis and in several cases of phthisis in the latter stages, the drug proved unsatisfactory; in two patients with phthisis, however, it relieved the dyspnœa wonderfully. In one of these the respirations fell from 52 to 28 after teaspoonful doses of the extract every two hours. Dr. Picot not only gave quebracho with good results to three patients with catarrhal pneumonia, bronchial asthma and cardiac disease, dyspnœa being in each an urgent symptom, but he experimented on himself with it as to its effect in diminishing shortness of breath in climbing hills. On three following days, the temperature and height of barometer remaining nearly unaltered, he ascended the same height in the same period of time. On the first day, without quebracho, his respirations rose from 16 to 42; his pulse from 74 to 94. On the

second day, half an hour before starting, he took fifteen grammes of Penzoldt's extract, and reached his destination with respiration at 30 and a pulse at 80, feeling also in every way easier, as was further proved by his being able to smoke during the ascent, which he could not at all manage the day before. On the third day, without quebracho, his symptoms corresponded to those of the first day. He has also seen good results in two persons without evident organic disease, but liable to breathlessness in walking fast. We must not omit to mention that Professor Skoda, of Vienna, has not only himself found benefit from quebracho, but has prescribed it for others with success.

It is possible that as an astringent in diarrhœa the resinous residue of the bark, which is only soluble in alcohol, may be of service. Dr. Berthold noticing that the diarrhœa of a phthisical patient stopped while taking quebracho, has tried the resin in acute and chronic intestinal catarrh with good results. To children he gives 0.1 gramme in a pill, of which they take ten daily.

CASE 19.—In a recent number of the *British Medical Journal* Dr. Burkart speaks in high terms of quebracho as a remedy for dyspnœa. He tried it in cases in which the dyspnœa was associated with emphysema of the lungs, atheroma of the arteries and degenerations of the cardiac muscles, and in every case the quebracho afforded immediate relief. In three minutes after the administration of the drug the pulse became somewhat fuller, but not increased in frequency; the patients felt their breathing easier, the face was flushed and a gentle perspiration appeared on the forehead; slight drowsiness and inclination to sleep were noticed. These symptoms soon subsided, but the breathing continued to be much improved.

CASE 20.—I have used the fluid and solid extract of quebracho with much satisfaction. One case of periodic asthma, in a French-Canadian girl of 15, employed in the spinning department of a worsted mill, seems to me worthy of special notice. Under belladonna and bromides her attacks were relieved so long as she stayed out of the mill, but immediately returned on going back to work. Through a misunderstanding she went to work while taking the quebracho, and, to my surprise, has continued to work, free from the asthma so long as she takes the medicine. Her trouble, however, returns so soon as she omits her usual dose (℞ xxx, t.i.d.). I do not attempt to explain how the remedy acts in this case. (Dr. Philip Kirtledge Taylor.)

CASE 21.—Not long ago I was called to see a boy of 10 who was annually the victim of hay fever, which usually runs into spasmodic asthma. At the time I was called he had not had

any sleep for several nights, and had been obliged to sit bolt upright all the time, and his breathing was so labored that he was a most distressing object. I gave ipecac and hyosciamus, but his next night was as bad as ever. I then determined to try aspidospermine, the alkaloid of quebracho, which I procured of Parke, Davis & Co. Thirty grains were triturated with 500 grains of milk sugar. Of this I prescribed 3 grains every two hours. (The maximum quantity which can be given in one dose, according to Merck, is $\frac{1}{10}$ grain.) The next night the patient could lie down—and got several hours good sleep. The medicine was continued several days with continuing improvement, when his father took him away to Ashland, Wis., the paradise of sufferers from hay fever. I have since used it in a similar case in an adult, with good results. (Dr. E. M. Hale.)

CASE 22.—C. H., male, 36, patient at Presbyterian Hospital. This was a case of asthma, complicated with old pleuritic adhesions and with a recent attack of acute articular rheumatism. The dyspnœa came on in paroxysms of great severity. When the first dose of quebracho was given, March 10, 1881, the patient was sitting up in bed, his face purple, lips livid, breathing very labored, shoulders elevated with each inspiration. Gtt. 40 of Squibb's fluid extract were given, and in fifteen minutes there was perfect relief, which lasted, however, only twenty minutes, when the difficult breathing returned. Another dose was then given, from which complete relief was obtained, lasting an hour. For the next twenty-four hours the attack was less severe. On the following day, March 11th, the dyspnœa not being urgent, a dose of gtt. 40 was given, and the effect upon the respiration was observed. In fifteen minutes it had fallen from 27 to 20. At the time of these observations the patient was taking gr. x of salicylic acid and 5ss of dialyzed iron, t. i. d. The dyspnœa not recurring, the quebracho was discontinued. (Dr. A. H. Smith.)

CASE 23.—The case was that of a little girl 4 years of age, with inflammation of the lungs from reckless exposure. She had been sick three or four days, growing gradually worse, until her condition became such that I had grave fears of her life. In this extremity I commenced the use of quebracho, fluid extract, gtt. ij, every two or three hours. Improvement came very soon; in twenty-four hours she seemed out of danger and made a satisfactory recovery. (Dr. H. H. Baker.)

CASE 24.—I have been much pleased at the effect of quebracho in the pneumonia of old people. I give it now as a matter of routine, and fully believe it has saved the lives of three persons of over seventy years of age and feeble constitutions—exactly such cases, indeed, as I had come to believe in-

evitably fatal. One must not, however, rely on it alone, but should administer the other usual remedies in such cases. (Dr. Philip Kittredge Taylor.)

The analogues of quebracho may be named in the following order :

(1) Coca and arsenic are the nearest. The former has a similar sphere of action, and its effects are better in acute cases where quick results are desired. The latter is better in chronic cases where we desire a deeper constitutional restoration of weak respiratory organs.

(2) Kola, like quebracho, is a respiratory stimulant, but is not so effective for acute dyspnœa, but like coca is better for the "want of breath" from walking or climbing.

(3) Coffee, and all drugs containing caffeine, such as thea, ilix cassine, ilix paraguaensis and strychnine, have many points of resemblance to quebracho.

Observations.

In summing up the results of the clinical experience with quebracho and its alkaloids we arrive at the following conclusions :

(1) That its principal sphere of action is that of a stimulant of the respiratory centres.

(2) That it is an analogue of strychnia, coca, kola and ammonia.

(3) That it is only palliative in organic diseases, such as cardiac, renal and pulmonary lesions ; also emphysema, bronchial catarrh and pleuritis.

(4) That it may cure in nervous or functional disorders, such as hysterical, nervous or reflex dyspnœa.

(5) That it is useful in cases of exhaustion and over-stimulation of the respiratory centres.

(6) I would advise the use of quebracho in the breathlessness of old people. One of the most noticeable symptoms of the decline of life is a "want of breath" during exertion. Even if the old man has been a mountain-climber in his youth or middle age, he finds after he is sixty that he cannot walk fast, especially up hill or against the wind, that his breathing is shorter and more rapid. This is due to atrophic changes going

on in the lungs and the muscles of respiration—possibly in the respiratory centres. In such cases moderate doses of quebracho or its alkaloid will enable him to exercise with more comfort.

In this respect it acts like coca and kola. Dr. Picot's experiment, recorded above, is proof of this. Even if the breathlessness is due to cardiac hypertrophy or fatty degeneration, or fatty heart, quebracho ought to prove palliative, because it imparts some tonicity to the heart as well as the respiratory centres.

THE VALUE OF VARIATIONS OF TEMPERATURE AS INDICATIONS FOR TREATMENT IN DISEASES OF CHILDREN.

BY W. H. BIGLER, M.D., PHILADELPHIA, PA.

(Read before the Homœopathic Medical Society of Pennsylvania, Pittsburgh, Sept., 1898.)

In the treatment of disease in children it must be remembered that their nervous system is in a state of immature development, and that the co-ordinations and connections with the reflex and cerebral centres are in a formative stage, and that, therefore, the reactions to stimuli, both from within and from without, are apt to be excessive, and the resultant objective symptoms more dangerous in appearance than in reality, as regards prognosis. It becomes, hence, of the utmost importance in all cases to exercise all our powers of observation, when examining our little patients, that no circumstance, however trifling, may be overlooked which might be the cause of apparently remote symptoms.

This holds good particularly in estimating the significance of oscillations in temperature. We believe that even in the treatment of disease in adults the clinical thermometer has been, and still often is, a much-abused instrument of precision, and that its indications for treatment, when taken alone, as is so often done, are misleading and mischievous. It is, however, especially in diseases in children that the greatest care is to be exercised not to allow these indications to have too great weight in our diagnosis, prognosis and treatment.

There is not in the whole human system, from a physiological

standpoint, a more interesting subject than that of the regulation of the temperature of the body—thermotaxis. The beautifully co-ordinated mechanism by which, under the most varied circumstances, the temperature is normally kept constant, needs to be thoroughly understood if we would appreciate the true value of the changes which occur in disease, and more particularly in children.

As we all know, the immense amount of heat generated within the body is so dissipated and its production so regulated that the temperature of the blood remains pretty constantly at 100° F., in the adult. In children it is somewhat higher, and in infants considerably so, and this under perfectly normal conditions. The thermometric mechanism is therefore "set" at one period higher than at another, and the various means for keeping a certain temperature are so co-ordinated as to produce this result. We cannot doubt that the higher norm in the infant and child is one of the numerous provisions of Nature for the protection of the individual against the injurious influences which threaten him during these periods, especially in a natural condition. In these years, and until the definite adult norm has been established, the heat mechanism is in a state of unstable equilibrium, and the variations in heat-production (thermogenesis) and heat-dissipation (thermolysis) are much more marked, and more readily produced, but, on that very account, much less significant. While, therefore, variations in temperature may have their significance, the degree of variation will not be proportionately important.

This is the point of this paper, and one which I have considered of sufficient moment to bring before you, to assist in the reaction against the antipyretic craze, which, by the aid of the various coal-tar preparations, has filled many a premature grave. I have so often seen the unnecessary alarm of the physician, and through him communicated to the family, caused by what, in the adult, would have been an alarming rise in temperature, occurring either suddenly in the midst of apparent health, or in the course of some other indisposition. In consequence of such misunderstanding of the true value of the symptom it has been taken as an indication in treatment to the damage of the patient.

Of course we will find in children, as we find in adults, certain types of thermometric changes, hectic, typhoid, etc., marked

by well-known diurnal variations, but what we wish here to emphasize is the fact that within these types, as well as in the general fluctuations of temperature, the degree of variation is in most cases in children not only a useless but even a misleading indication for our prognosis and treatment.

Among the circumstances apt to cause a rise in temperature in the child out of all proportion both to the cause and to its consequences are gastric, but more particularly intestinal, disturbances. Acute indigestion is very prone to raise the temperature, especially after the offending food has left the stomach, lasting until it has left the body. Occasional constipation is often accompanied by a rise in temperature to a degree which, if taken by itself, would be sufficient to cause alarm. Emotional disturbances of all kinds, excessive exercise of mind or body, may initiate an unbalancing of the thermotaxic mechanism, resulting in an exceedingly high temperature, which proves itself, without treatment, to be perfectly harmless. During the course of other diseases the fall in temperature following the crisis is frequently so great as to call forth groundless apprehension, and prompt a recourse to measures which, if not harmful, are at least unnecessary.

To sum up: While decided variations in the temperature of children should cause us carefully to search for a cause, the degree of variation does not furnish us with reliable indications for prognosis or for treatment.

GLIOMA RETINÆ ENDOPHYTUM; A CASE.

BY E. W. BRICKLEY, M.D., YORK, PA.

(Read before the Homœopathic Medical Society, State of Penna., Pittsburgh, Sept., 1898.)

THE rarity of glioma retinans and the desire to obtain more information through discussion by members of this bureau upon a subject, the diagnosis of which is so often made upon the expectant plan, must be accepted as my chief reason for presenting this paper. In a varied and somewhat extensive ophthalmic practice, covering a period of nine (9) years, this has been the first case of its kind presented to my notice,

although having been fortunate enough to have had the opportunity of examining one in the clinic of Fuch's, at Vienna, during my course of study there in 1889.

The course run by the disease in this particular instance was somewhat peculiar, viz., the length of time elapsing before the eye attracted sufficient attention to deem the services of an ophthalmologist a necessity; the failure of the microscopist to detect the true nature of the growth; the (rarely observed) detached retina, not often seen in the endophytic type; the paralytic symptoms presenting in the latter stages of the disease; and, finally, the extended period of suffering endured before the curtain was rung down upon the final act of an agonizing existence. With this preface, then, allow me, as briefly as possible, to outline the following case, which presents so much of interest and vital importance:

Ruth H., a bright little girl of 5 years, was brought to my office October 23, 1895, "to see what made her left eye look so funny." Upon examination, found her general condition excellent and no apparent constitutional taint whatever, with the exception that within the previous week she had been drooping and complaining of her left eye, which on inspection presented the following appearances, copied into my case-book at the time:

Cornea perfectly clear, and both palpebral and bulbar conjunctivæ normal; a slight divergent strabismus of the affected eye. Of the iris nothing could be seen, the pupil occupying the whole of the corneal space, and through opening shone a bright yellow gleam, which at once suggested the existence in the second of the fatal "glioma." Vision was absolutely nil. An ophthalmoscopic examination revealed a somewhat nodular tumor springing from the macular region, upon the surface of which a few blood-vessels ramified, while grayish wavy patches, brought to view with + lenses, seemed to indicate a retinal detachment. A few crystals of cholesterina crystals floating in the vitreous completed the interesting picture. The statements of the parents were to the effect that for several months previous the child's eyes had "looked queer," but nothing was thought of it until the bright yellow gleam was noticed a short time before presenting her for treatment. A diagnosis of "glioma retinæ endophytum" was given and

immediate removal of the eye advised, which advice was not accepted by the parents, who, being entirely unaware of the inevitably fatal consequences which were sure to occur, naturally objected to what they at the time regarded a procedure too radical to be countenanced. Since their consent to an operation could not be obtained, it was agreed that the case should report to me every few weeks for examination, and for nearly two years this was faithfully carried out, the only treatment for the first few weeks being doses of potass. iod. and locally a soothing collyrium, the latter prescribed more for the purpose of convincing the parents that something was being done than with the hope that any treatment short of removal would hold out the slightest prospect of relief. On July 1, 1897, the patient presented the following conditions: General condition bad; anæmic and unable to sleep, owing to constant headache; anorexia and characteristic cachexia were present; eye rather more prominent and bulbar conjunctiva much injected; the cornea at superior and exterior quadrant bulging and on point of breaking down, while the vitreous chamber seemed well nigh filled with the growth; In + 2. Immediate removal was again urged, but was not permitted until the 6th inst., when after some difficulty the ball with quite a portion of optic nerve was enucleated. The recovery from operation was uneventful. Upon section of the globe antero-posteriorly a nodular tumor was found sprung from the region of the yellow spot and almost entirely filling the vitreous cavity. The retina was detached fully three-fourths of its extent; the choroid atrophied in spots; the iris conspicuous by its absence.

Desiring a *positive* diagnosis as to the exact nature of the growth, it was sent to a student friend, who in turn submitted it to an expert microscopist. The latter, after several weeks spent in hardening the specimen, finally succeeded in obtaining a section which he pronounced, after due examination, to be that of a simple fatty tumor of the retina. Dubious as to the correctness of this result, but knowing it to be the best available, I informed the family of the probability of an entire recovery. The reverse, as the sequel showed, proved that my suspicions were correct, as within three months trouble again became apparent in the orbit, there being much irritation and excessive lachrymation which nothing seemed to control, and

finally the dreaded excrescences of encephaloid were plainly in evidence. From this time up until the hour when Death dropped his sable mantle over the scene, her existence was one of incessant suffering. Total blindness of the right eye ensued, together with loss of hearing, while an entire paralysis of all the extremities completed a picture pitiable in the extreme. The orbit became filled with a hideous mass of granulations, which extended for several inches beyond the supra-orbital line, these at times breaking down and discharging a fœtid sero-pus, only to speedily re-form and repeat the process.

Death finally occurred on August 28, 1898, about a year and six weeks from the time of removing the eye. It may be stated, in closing, that the general treatment of the case was almost solely confined to the tonic form, the multitude of symptoms serving to confuse rather than aid intelligent prescribing according to the law of "similia." Opiates, of course, were necessarily used in heroic doses to give some needed rest to the tortured body.

The paralytic condition of the extremities seems to be unusual in this disease, at least it fails to appear in the literature consulted, the patient usually dying of exhaustion long before the brain becomes involved to such an extent as to cause loss of muscular power. Why the microscope failed to reveal the true state of affairs I am at a loss to comprehend, unless it can be attributed to the difficulty in obtaining a good, smooth section, the specimen being exceedingly friable. These queries, together with others which have doubtless presented themselves to you as the paper has been read, will perhaps promote a discussion from which the writer hopes to glean some much desired information.*

LOLIUM TEMULENTUM IN TREMBLING OF THE HANDS AND FEET.—Dr. Boner observed a carpenter, of 39 years, who, from his eighteenth year, had trembling of his hands, which was especially pronounced mornings; latterly his legs had begun to become tremulous. Curiously enough, his father and one brother were subject to the same disease, without any cause being known. He received at first mercurius, and then agaricus, which latter relieved partially but only transitorily. Finally, *lolium temulentum* 3x was administered, which in a short time led to restoration to a normal state.

* The mounted section was also submitted.

TREATMENT OF LEG ULCERS.

BY J. W. HASSLER, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society, State of Penna., Pittsburgh, Sept., 1898.)

THE views as expressed in this paper were acquired from the treatment of some fifteen hundred cases in the surgical dispensary of the Hahnemann Hospital of Philadelphia. The treatment of ulcers is varied, and each and every physician has his or her peculiar powder, antiseptic lotion, ointment, or manner of application of dressings. We have not been biased in our treatment of these cases, but have applied the different ointments, powders or lotions as advised with partial or no success, finally coming back to the recognized stand-bys, an explanation of which will follow.

An ulcer is a solution of continuity caused by molecular loss of tissue; therefore, healing is by second intention or granulation. Different varieties are spoken of, but for simplicity we will classify them into but two. 1. The simple, healing or aseptic ulcer. 2. The septic or sloughing ulcer. All ulcerations are amenable to a general line of treatment surgically, differing only as to their dietetic or medicinal adjuvants. We will consider, first, the simple, healing or aseptic ulcer—a form all ulcerations must attain before healing; or, being a simple ulcer from traumatism, etc., through an accidental condition may be caused to change its characteristics and become a septic ulcer. We have found that a plain antiseptic dressing, preferably a corrosive sublimate solution, changed every day, will cause a rapid advancement of the epithelial covering desired.

The following method has been found beneficial by causing healing under a crust, viz., by dusting on of aristol, which forms, with the lymph, a glutinous covering; being only applied when the granulations are level with the epidermis. Aristol possesses tremendous cicatrizing powers, therefore it should not be used in deep ulcers where it is necessary to recover a loss of substance. In these conditions a dry dressing should never be used, but a moist one—bichloride of mercury, carbolic acid or formalin solution. I would advise against ointments of any kind; from

observations they cause a dirty-appearing wound, and are liable to septic change. It has been said, in favor of ointments, that they cause a constant humidity of the wound, the ointment preventing the drying of the wound by always keeping a light layer of lymph upon the surface. But this one fact, accumulation of lymph, may be the hot-bed for septic infection by accident. Another theory advanced is the facility in changing dressings, as they do not adhere, and can be removed without injuring the granulations and causing a laceration of the newly formed capillaries. With patience and free irrigation of the dressing with your antiseptic solution you will be able to loosen them so as to cause no injury to the granulations. It has also been observed by us that the adhesions of the dressings are not to the granulating surfaces, but to the healthy unruptured skin surrounding the wound.

In cases of simple ulcers, more or less deep, the granulations frequently become soft and pale. To cause a healthy proliferation it is necessary to irritate the surface so as to cause an exuding of plastic lymph. This irritation should not be obtained with caustics, or any substance which will necrose the tissues. Boric acid, or a 10 per cent. powder of boric acid and iodoform are certainly the superior agents, causing sufficient irritation without injuring the healthy tissues beneath. Frequently the granulations become exuberant. To restrain the overgrowth, nitrate of silver or scissors curved on the flat will remove them. It has been advocated in favor of the nitrate of silver pencil that by a specific action it accelerates the formation of the epidermis.

In regard to septic ulcers we class all continuities of the tissues which are undergoing degeneration from microbial implantation. Of these we have the fungous ulcer, due to an interference with the return circulation of the blood; inflammatory ulcer of the drinker; sloughing ulcer, seen in connection with venereal diseases or sexual excesses; phagedenic ulcer, due to the multiplication of a specific micro-organism in the tissues broken down by intemperance, bad blood, etc., and is usually of venereal origin; indolent or chronic ulcer, the most prevalent of all ulcers, where the granulating surface has its healing process interfered with by some irritation, mechanical or otherwise; epidermis is prevented from forming, the

margin and base are formed of dense fibrous tissue, causing them to adhere to subjacent fascia; this cicatricial tissue cuts off the arterial supply, preventing the formation of healthy granulations; varicose ulcer, due to an interference with the venous return.

In the treatment of septic ulcers, their ætiology must be taken into consideration. If due to interference with the return circulation, by position favor the return of venous blood and by the indicated remedy support the circulation. If from alcoholic and sexual excesses, poorly nourished condition or local irritation, stop excesses, change diet and remove irritant, together with a general tonic treatment. If of a specific origin, the usual remedies in those conditions. The varieties most commonly met with by us have been the indolent, varicose and phagedenic ulcers. In a dispensary practice, the usual condition of a wound, on first presenting itself, is sloughing in character. First treatment is the thorough removal of all sloughing tissue by curettement or cutting; if condition is moderate, nitrate of silver. Lately, I have used in two cases, for the removal of sloughs, papoid. It will digest and almost liquefy a slough in from twenty-four to thirty-six hours. If it will do this in every case, we can abandon the painful methods of curettement and cutting. Following the removal of the slough, the first dressing consists of wet bichloride of mercury gauze; the subsequent dressings depend on the appearance of the wound. If ulceration is deep, boric acid powder is used, filling up the cavity. The external dressing in this as in all cases is wet gauze, saturated either with bichloride of mercury, carbolic or formalin solutions; depending upon the susceptibility of the patient to withstand bichloride. If the skin becomes irritated by it, we change to carbolic or formalin. If the wound is more superficial, 10 per cent. powder of iodoform and boric acid is applied. Picric acid solution, consisting of picric acid, grains, $37\frac{1}{2}$, alcohol, ounces, 1, aq. dest. 1 pint, has been of service, especially where the lesion is extensive and superficial, applied upon gauze. The granulation remains clean and bright; the epidermis forms rapidly.

In the chronic or indolent ulcer, as the usual condition is that of cicatricial margin and base, causing a choking off of the circulation, removal of the condition is advised, or radiating in-

cisions through the margins and base. Frequently the power to reproduce epithelium is lacking in connection with unfavorable physical conditions. Skin grafting is then indicated. In some instances amputation has been resorted to. The dressings are according to conditions, whether deep or superficial, sloughing or not; to be applied as previously indicated.

Two very interesting cases of indolent ulcers are being treated at present. Mr. G., negro, 40 years of age, servant. Swelling of the leg two years ago; breaking down of the tissues between the knee and ankle; came to see us December 12, 1897. Leg larger than thigh, horny and wrinkled skin at ankle, ulcer encircling leg from ankle to midway up leg. Diagnosis, lymphædema. Thorough curettement and antiseptic dressings were applied, with pressure bandages of muslin for two weeks, followed by the picric acid solution. The result was surprising; the granulations picked up and a number of small openings healed in six weeks; from that time very little progress was seen until the past two months. Different powders had been used with little or no success. The odor was heavy and penetrating. Boric acid powder had not been used on account of the superficial condition. It was applied two months ago simply as a deodorant; the change was remarkable. The odor was destroyed and the ulcerations are healing rapidly; new epidermis is seen at every dressing. The wound measures but three inches in length and one and a half inches in width. The size of the leg is normal at the present time; pressure bandages had been applied during the entire treatment. When he first applied amputation had been advised, but he refused.

Mrs. B.; white; age 30; servant. Indolent ulcer for seven years, encircling entire limb, just above ankle; width three inches. Came under our observation six months ago. Received similar treatment as the previous case; progress slow, due, no doubt, to the lack of attention, being unable to report but twice a week. The wound has become smaller, measuring but an inch and a half in width at the present time. Boric acid powder is being applied with iodide of potassium, 25 drops three times daily. Recovery doubtful. Cause of ulcer, syphilis.

PYO-HYDRONEPHROSIS.

BY C. I. WENDT, M.D., PITTSBURGH, PA.

Pathologist Pittsburgh, Homœopathic Hospital.

(Read before the Homœopathic Medical Society, State of Penna., Pittsburgh, Sept., 1898.)

MR. N., age 45, admitted to the hospital about November 10th, suffering from uræmic symptoms.

Urine 400 c.c., turbid, alkaline and foul-smelling; contained albumin—no casts. Passed in quantities of 2 to 3 ounces; headache frontal and occipital; anorexia and vomiting. Frequent chills. Physical examination revealed tumor in region of right kidney—rounded and slightly fluctuating—displacing liver to left.

A similar but smaller tumor found in region of left kidney.

Diagnosis of double pyonephrosis. Death resulted on fourth day. Autopsy six hours after death.

Liver, normal size, pushed against abdominal wall, the left lobe touching spleen; ascending colon pushed aside toward median line. In right kidney-space a large cystic tumor was found, tightly bound down by tough adhesions. The ureter was searched for and found to lead up to this cyst. A similar cystic tumor with attached ureter was found on left side. The kidneys, two ureters and bladder were removed entire for examination. The urethra was explored and a stricture situated in the membranous portion found, but owing to post-mortem relaxation its character could not be definitely determined.

Examination of bladder-wall showed a great hypertrophic thickening—so much so that the rigidity of its walls prevented collapse and the bladder presented the appearance of a round rubber ball. The walls measured from 1 inch to $1\frac{1}{4}$ inches in thickness, and the capacity of the vesical cavity was reduced to between 2 and 3 fluid ounces. The mucous membrane was in thick dense folds and of a dark bluish color. Ureteral openings were patent. The thickened sections of bladder-wall showed great increase in muscular fibres and connective-tissue growth, and infiltrated by large numbers of small round cells.

Ureters found to be greatly thickened—measuring from $\frac{3}{4}$ to 1 inch in diameter—tortuous and lengthened.

The lumen of the tube showed many dilatations permanent in character, and many strictures, several of small calibre, and numbering in the right ureter 5 in the left 3.

One in the right measured about $\frac{1}{32}$ of an inch, and, owing to its being situated in a kink, would allow but a drop of water to flow through at a time.

Pelvis of right kidney enormously dilated and greatly thickened. Capsule also dilated and thickened, measuring in places $\frac{1}{8}$ to $\frac{1}{4}$ -inch in thickness.

Contents measured 600 c.c., consisting of fine alkaline, chocolate-colored fluid containing many pus-cells and crystals of triple phosphates; specific gravity, 1009.

A small portion of kidney tissue was found, consisting of a portion of cortex. Microscopic examination showed atrophied kidney cells, portions of tubules and broken-down glomeruli of pale color, and so disintegrated as to be capable of but little, if any, functional activity.

The cystic kidney measured about 8 inches in length and 6 in width. The cavity of the cyst showed spaces corresponding to the dilated calyces.

The left kidney presented practically the same conditions, except that the kidney substance was present in considerable amount—more than normal—showing an effort on the part of the organ to assume the function of its degenerate fellow.

It contained about 150 c.c. of fluid—about same as right; specific gravity, 1013. Microscopic examination revealed a condition of granular degeneration, owing to the increased burden thrust upon it.

A meagre clinical history of the case previous to admittance was obtained through the kindness of Dr. H. G. Briggs.

Eight or ten years ago patient contracted gonorrhœa, and from it inherited a stricture. Off and on for three years he had suffered from "rigors," and was treated for malaria. Spent several months in Mercy Hospital, this city, where malaria was diagnosed. Needless to say—owing to faulty diagnosis—no good results followed such treatment. Was finally compelled, by reason of increasing symptoms, to quit work and come to hospital.

It is my opinion that the stricture caused hypertrophy of the bladder and finally a hydronephrosis; and, owing to some dirty

instrument having been used in urethra or bladder, infection resulted, which quickly ascended to ureters and finally reached the already distended pelvis, where the germ had an ideal habitation.

Evidently the primary kidney *infection* was unilateral—affecting only the right kidney and ureter—the left becoming enlarged in the effort to do its double work. When the left was infected, nature gave up the fight and uræmic symptoms developed—then death.

NOTES ON NEW REMEDIES.

BY MALCOLM MACFARLAN, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society, State of Penna., Pittsburgh, Sept., 1898).

SHEEP THYROIDS, desiccated and prepared by Armour & Co., of Chicago, carried by the writer to the 30th potency, decimal scale—using pure water. Experiments with the dynamized preparation were commenced more than a year ago to gain a clear idea of its principal physiological or remedial action. Following out a plan pursued for years, it was given often, and for several days, to a great number of persons slightly ailing, but not aware of being provers, jotting down as well as keeping in memory the various answers. The prime symptoms were sighing, disturbed and unequal respiration, anxiety about the chest, as if constricted or as if the movements were obstructed by tight clothing. The prover is often aware of making efforts to breathe, and does not act as if this function was without effort. The laryngeal symptoms were not marked, and confined to more or less slight clearing of the throat and upper air passages. This chest constriction lasted but a short time, varying from a few moments to an hour or longer, and showed a disposition to recur several times during the day. With this sighing was rapid heart action, fear, nervousness and anxiety, indisposition to exercise. The majority of the provers were women. From many no results were obtained; only those symptoms were retained which seemed to be constant or present in all the provers.

Acting on the general answers obtained, the remedy has

given marked curative results in various forms of asthma or similar symptoms; has helped hysterical cases with occasional disturbances of respiration and mental state mentioned above. Extraordinary good results were obtained in two very old cases of exophthalmic goitre, as to improving the respiration. Much help has been given in that common condition of short breathing in the aged largely due to changes in the vessels. It has been tried many times for the relief of cough, bronchial or lung trouble, but without benefit. It seems to help chest symptoms due to spasms or nervous irritation. It ought to be of service in whooping-cough, as far as its spasmodic action is concerned, but no trial was made of it.

Functional or sympathetic disturbance of the respiration is a most distressing and common symptom noticed in many diseased conditions and often difficult to relieve. Perhaps thyroid extract might be found of service in some such cases. Minor symptoms, affecting the head and eyes, were noticed but not recorded, because not constant. In an exhaustive proving they would be of use in completing the picture of the proving. The busy man wishes to avoid mental confusion by the recital of hundreds of symptoms, without being shown their relative force and importance.

Protonuclein, prepared by Reed & Carnrick, of New York, was carried to the 30th potency, decimal scale, using water. The work has not been done on this remedy in as thorough a manner as the former, but what was noticed during provings was a marked effect on the enlarged tonsils of children. On this suggestion, given clinically for a case of chronic scrofulous enlargement of the cervical glands, the effect for good was speedy and permanent. Subsequent curative action has been noticed several times in similar cases of glandular swellings, particularly in children. A young and otherwise healthy clergyman, who had been afflicted for two or three years with successive crops of boils, never disappearing altogether, inso-much that he was compelled to give up his charge, had been under various kinds of treatment, such as powerful crude medicines, restricted and special diet, and a course of baths at Sulphur Springs, was quickly cured with this remedy in the 30th potency. In a case of long-lasting enlargement of the cervical lymphatics of the neck, due to syphilis, the cure was rapid and

complete. This remedy has no doubt a wide range of usefulness, but will require patient effort to determine its more exact curative sphere.

From the New York Pasteur Institute was obtained an active fluid containing the "*Bacillus prodigiosus and erysipelas toxines.*" This was carried to the 30th potency, using water. More or less experimental work has been done with it for the past two years, with surprising and singular results in some cases. The most constant symptoms were chilliness, coldness, nervousness and shaking, lasting as a rule only for a few minutes, but frequently recurring during the day. There was no fever nor sweat following this; simply a mild reaction, with a feeling of weakness and some nausea. The mental state was, fear that some serious sickness was coming on. From what could be learned, the urine was diminished in quantity and darker than would be explained by being scanty. Taking another view of it not derived from its proving, but as the poison of erysipelas, the potentized preparation was given with immediate help in a case of gangrene of the lower extremities, attending advanced diabetes mellitus. Surgical means were used to excise the parts, but numerous gangrenous spots on both legs quickly took on healthy action after the use of this remedy, and no more appeared. The diabetic condition, however, was in no wise helped, but it appeared as if a speedy fatal result was averted. This was a remarkable case. Led by the partially successful work done by others in the use of these toxins in the local treatment of some forms of malignant disease, it appeared that the potentized remedy might be of service in such cases. It was given a faithful and prolonged trial in several, principally of sarcoma and scirrhus, without any benefit whatever. It is believed worthy of use in cases of blood poisoning, sloughs, wounds which are septic, malignant scarlet fever, malignant pustule, sloughing of the skin of the lower extremities in advanced kidney disease, etc.

Ichthyol.—A fossil product of complex structure, containing within itself a high percentage of sulphur in soluble form, elements of the coal-tar products, with much else beside. This is destined to be one of the most remarkable and generally useful remedies given internally. Its action on many diseased conditions affecting the skin, kidneys and mucous surfaces is

often prompt and helpful. There seems to be nothing better in the treatment of the obstinate winter coughs of old people, so difficult to help. A chronic case of diabetes mellitus, in its last stages, was so affected by long-lasting, intolerable itching, with raw, fiery patches about the thighs and genitals, that she was in extreme misery. The 30th decimal of the remedy brought permanent relief from the skin symptoms and itching in a few days, and unexpectedly limited the amount of urine passed. While there was no real improvement in the diabetes, yet the change for the better as to the skin was immediate, lasting, and remarkable. In the discolored, scaly and itching eczema of the lower extremities, so common in middle-aged and elderly people, whose habits have not been correct, its results are best seen. The disease is usually chronic when first met by the practitioner, and all sorts of local and internal remedies have been tried without avail. Ichthyol diluted is a most soothing and grateful application in erysipelas—it is to be considered here as a powerful and harmless antiseptic, and is useful internally also. It is well known how helpful is potentized sulphur in certain stomach and bowel symptoms. It is difficult to make or get a solution, even of a small quantity, but it exists in such an amount and in so soluble a form in ichthyol that the latter may be given, often, as a substitute.

When ichthyol, 30th, is given internally for several days, it produces heat and irritation of the skin, disposition to soft, shapeless stools, and frequent urination.

A STUDY OF SILICA, WITH NOTES ON ATTENUATION OF DRUGS.

BY EDWARD CRANCH, M.D., ERIE, PA.

(Read before the Homœopathic Medical Society, State of Penna., Pittsburgh, Sep., 1898).

SILICA, as a remedial agent, is one of the most useful helps that the true physician can employ, but it is blindly avoided by the old-school doctor, who styles himself “regular and unrestricted,” yet “prefers charges” against any of his fellows found guilty of “practicing Homœopathy,” using the “little pill” or the “tasteless glass.”

Silica can show the world, if it will listen, what Homœop-

athy has done and is doing for science, both in excellence of remedies and in convenience of dose.

Let us review briefly some of the best-known and most generally used indications for silica. It will cause and cure felons, foot-sweats, headaches, melancholia, nervous prostration, vertigo, catarrhs of several organs, ulcers, glandular swellings, caries of teeth and bones, dyspepsia, constipation, dysuria, fistula, paresis, and some forms of skin disease. Not that it will cure every case of all these varied ailments, but it will do so when the constitutional symptoms mainly agree.

In the general symptoms calling for silica we may note dependency, anxiety, ready fatigue, with the peculiarity that the patient will keep up till the immediate work in hand is done, and then collapse utterly. There is great sensitiveness to taking cold, especially if any change be made in the clothing, such as leaving off the hat, changing shoes for slippers, etc. There is an intolerance of alcoholic stimulants, and easy disturbance from tea, coffee, and narcotics. There is great sensitiveness to all sorts of impressions, starting at slight noises, patient is very easily hurt by incautious handling, and pain is not well borne. There are frequent night-sweats, and very often a fully developed hectic condition. Chronic ailments from bad vaccinations are relieved. The head especially is relieved in all its ailments by hot applications.

A severe case of chronic pelvic cellulitis, in the writer's practice, was cured by silica alone, the patient having frequent very severe headaches, only relieved at all by resting the head on one poultice and covering it with another. The cellulitis was discharging into the vagina from two long, fistulous tracks, and was entirely cured. All the sores and bone-diseases of silica suppurate freely, showing great susceptibility to septic influences, and these sores are painful, and readily yield up whatever foreign substances in the shape of bullets, glass, wood, or cloth, that may be imprisoned.

A case of nervous prostration in an old lady who had had several physicians in vain was promptly relieved, and accompanying night-sweats stopped, by silica alone; but the symptoms came back the first time the medicine was withdrawn, while, since its repetition further, the patient appears to be cured.

A case of multiple paronychia (Morvan's disease) was also

helped more by silica than by any other treatment, although it is not known now if it is entirely cured. Several cases of cracks or rhagades at the ends of the fingers, and many cases of whitlow or felon, have been promptly cured. Cases of dental fistulæ, and one case of anal fistule, have yielded to silica, without other aseptic treatment. Organic diseases of brain and nerves have been improved, and stiff joints restored to usefulness, and chronic neuralgias cured.

The foregoing is a very brief account of what silica will do in our hands. Now let us see how it is regarded by the old school. Out of a large number of text-books gone over, only three were found to mention it at all. These were the *National Dispensatory*, and Shoemaker's and Potter's works on *Materia Medica and Therapeutics*. These all allude, very briefly, to the antiseptic virtues of the solutions of the silicates of potassium and sodium, and speak of them as of possible, but very subordinate, use as washes in certain cases of cystitis, vaginitis and erysipelas. Pure silica is honored with only one mention, and that is where John V. Shoemaker, M.D., LL.D., says, on page 758 of the third edition of his *Materia Medica and Therapeutics*, "Friction with sand has been employed by Ellinger as a method of detaching the scales in psoriasis." According to Cathell, in his *Book on the Physician Himself*, "regular, unrestricted" physicians always "eagerly, and fairly, and deliberately investigate and test all the alleged important discoveries." Why is it, then, that they have rejected the right use of silica, and brought up on sandpaper? "To what base uses we may return, Horatio!" and this in the close of the wonderful nineteenth century. Something very like it was recorded about five thousand years ago, when the patient patriarch Job applied the silicated edge of a broken plate to his justly celebrated boils or small-pox pustules! Men like Cathell still ask, "What has Homœopathy done for science?"

Apart from a renewed demonstration of the law that the reactions of living tissues are exactly opposite to the direct actions of drugs of all kinds upon them, we have in silica a powerful exemplification of what is every day being accomplished with our methods of trituration and attenuation, proceeding in regular geometric progression, in the presence of a neutral medium. Our methods make available, without the formation of soluble

salts, the most insoluble substances, such as silex, graphite, charcoal, sepia, and the pure metals and metalloids, and they enable us to use safely, without dilution, through calves, horses or guinea-pigs, the most virulent poisons, ptomaines, disease-products, snake and spider poisons, and alkaloids of the greatest activity.

But because these methods lead to the "little pill" and the "tasteless glass," the "unrestricted" "regular" dare not use them, lest he incur the heinous charge of "practicing Homœopathy," than which, in some eyes, there seems to be no greater folly or crime. How much senseless ridicule has been thrown upon the homœopathic system of attenuated doses by even such well-meaning minds as those of Dickens and Darwin, of Huxley and Holmes!

Tyndall, whose studies lie much among the little things and lesser-seeming forces of nature, has a good word for us when he likens the action of the infinitesimal dose to the vibration of the tinkling bell on the collar of the Alpine mule, the gentle force of which is sufficient to start the ready and destructive avalanche. So the atoms of the first or second order in silica, in the third or thirtieth attenuation, do not have great force stored up in their feeble doses, but they serve to start the greater physiological forces of the living body into active resistance, and the result is an avalanche of power that will restore health if the vitality of the system be not too much depleted before the reaction begins. The atom of silica is to the complex "physiological unit," to borrow a phrase from Herbert Spencer, like the mustard plaster on the pleuritic thorax—it excites a healthy reaction; while, being pleasanter to use and under better control than the plaster, it naturally tends to displace it. So our "exclusiveness," of which so much capital is made by our opponents, is not from a puerile dogmatism, but solely because we reject the mustard plaster and the red-hot iron, since we have learned a better way. The old school, on the other hand, seem to be deterred from using our methods and doses solely from the fear of ridicule and social ostracism from their fellows.

In science it is always allowable to offer a new hypothesis to explain newly-found facts, and often the hypothesis of to-day becomes the proven fact of to-morrow.

Spencer, in explaining vital force, offers a hypothesis of the existence in all living tissue of certain "physiological units," supposed to be more complex than any yet demonstrated in dead matter; and by the ready decomposition of these, and the release of their imprisoned forces, he explains many of the phenomena of life.

Darwin, too, to account for heredity, supposes the existence in each cell of a living organism, a miniature copy of that cell, which he calls a "gemmule," and assumes that these are transmitted from parent to offspring; and so he explains the likenesses of succeeding generations.

Now, to help the mind to conceive rationally the action of high potencies, let us assume that each of the supposed ultimate atoms of each simple substance or element, and each of the supposed ultimate molecules of every compound substance, contains one or many included orders of atoms and molecules; that when Dalton, for instance, figures out by the laws of atomic weight the probable number of atoms in a grain of silicon, or of molecules in a grain of silica, each one of these particles really contains a million million of the next smaller order, and these again hold each a billion billion of a third order, and so on.

We can safely assume, from what we know of matter, that ordinary grinding and dissolving will not separate off any of these finer orders of atoms, but that they will retain their inward cohesion until some neutral medium is regularly supplied and renewed as the trituration progresses. This will serve, with the grinding and succussion, to keep separate and active the smaller orders of atoms.

By this conception of self-included orders of finer and finer atoms it is easy to see that the presence of real matter is not only possible but probable in potencies higher than the twelfth, where sticklers for the older atomic theory would have us stop, while the facts show that some other explanation of the situation is necessary, for silica and many other substances are active in the thirtieth, the two hundredth, the ten thousandth, and even higher. We cannot defend the nomenclature of the "fluxion" potencies, which is demonstrably much lower than is assumed, but we know they are productive of good results, however numbered.

One of the most logical objections to the use of homœopathic attenuations in any scale originated with Dr. E. M. Schaeffer, then of the Army Medical Museum in Washington. He said he could not conceive of a dose of silica, silver or iron being of use in attenuation as long as we eat off of flint plates with silver forks and iron knives, for we must constantly be getting similar small particles in every mouthful. To-day's hypothesis of different orders of atoms offers a solution to the problem, as it does to the wonder that we can cure chills and fever with attenuated atoms of common salt while the same salt is in the daily food. The explanation lies in the probable fact that the atoms in each case, though of the same substance, are not the same in size, because so differently prepared for use. It is easy to see, too, why lower potencies benefit some cases and high potencies are best in others, for the action of either is in accord with the kind of disturbance present in the organism of the body. Coarser and cruder doses fit best with some causes of disease that act on the lower degrees of bodily energy, while finer and subtler doses easiest affect the higher portions of the organism nearer to the mentality, more intimately vital, and often more apt to be chronic. In either case, close observation and frequent practice is needed to decide the dose. Some recent experiments of Nageli, of Switzerland, show wonderfully the power of high dilutions. Some copper coins were suspended for a short time in a glass dish containing water, in which was growing a water-plant of the species *Spirogyra*. This quickly died from the deadly influence of the copper, which was still exerted even when the coins were removed, the dish emptied, washed, boiled and dried. As soon as this *spirogyra* was put in, with fresh water, it died just as quickly as in the presence of coins, but did not die in other dishes similarly treated, but which had not had any copper about them. By this sort of "vital chemistry," which any one can verify, we may yet show that homœopaths are not such fools as they have been thought. In place of the microscope, the crude reagents of the test-tube, the balance and the spectroscope, all which deal only with dead matter, let us make systematic tests of our dilutions and tinctures on living matter, and we will yet prove our case to the most skeptical.

Even Darwin admits that very weak solutions may be very

active. To quote his words, he says: "The fact which appears truly wonderful is that the one-twenty-millionth of a grain of the phosphate of ammonia (including less than the one-thirty-millionth of efficient matter), when absorbed by a gland, should induce some change in it which leads to a motor impulse being transmitted down the whole length of the tenticle (of *drosera rotundifolia*), causing the basal part to bend, often through an angle of 180°. Astonishing as is this result, there is no reason why we should reject it as incredible."*

We have, then, no reason to give up our small doses of silica, nor to doubt this record of their effects, for the burden of proof otherwise is on those who contemptuously set aside everything that bears the hall-mark of Homœopathy. We only do our duty when we refuse to give up our discoveries and go over to those who show their desire to reject them all as visionary and unpractical theories.

DIARRHŒA AND INDIGESTION IN CHILDREN.

BY WM. A. SEIBERT, M.D., EASTON, PENNSYLVANIA.

(Read before the Homœopathic Medical Society, State of Penna., Pittsburgh, Sept., 1898.)

THE keynote of success in the treatment of diarrhœa and indigestion in children lies unquestionably in a comprehension of the causes at work. A removal of the cause will almost invariably be followed by immediate recovery. Add to this the help of the remedy indicated by the symptoms of irritation, and the combination for overwhelming the disorders becomes irresistible and the delight of the homœopathic physician.

Bacteriologists are busying themselves in the careful study of the various forms of bacteria in diarrhœa as well as in other diseases. They have singled out three varieties in the summer diarrhœas, and have named the most common one bacterium coli. They have learned that the ammoniacal products of these cause inflammatory disturbances, which in turn bring about degeneration of the mucous membrane of the bowels and allow the germs to enter the blood and lymphatics, and through these

* *Insectivorous Plants*, by Charles Darwin, p. 172.

the other viscera. They are carefully studying the virulence of these bacteria. This knowledge is not to be despised, and bacteriologists are to be encouraged in their untiring devotion to science.

It is necessary to heed their warnings that the increased virulence of the germs do cause inflammation and disease; but it is not necessary to agree that these bacteria are the primal pathogenetic agents, and that they are not concomitants or even scavenging in nature. They are proved to be common residents of the healthy intestines, and that their virulence is always dependent on other causes and conditions. It is right here that the homœopathic practitioner comes nearer to a comprehension of the subject than "his friend, the enemy." The "*condition*" referred to is that incomprehensible something that is so beautifully impressed by the proper remedy and turned toward the normal.

However, the treating very briefly with the "*causes*" is the burden of this paper. And the most potent means of combating them at our command, after prophylaxis, consists undoubtedly in the proper application of sterile water both by mouth and rectum—a measure so commonplace that we believe it is frequently undervalued. It should be thought of even though there is not an excessive diarrhœa; hypothermia, exhaustion or collapse are each equally good indications.

It dilutes the irritating contents of the bowels and removes promptly whatever may be poisonous. When given by the mouth it is best given every hour or half-hour in small quantities and to the exclusion of all other food, for even an entire day. Given per rectum in copious irrigations and repeatedly has produced marvellous results, probably because of its removal of the fermenting material, but also because of its effect on existing hyperæmia on the one hand, and again because it with equal promptness raises a menacing subnormal temperature to the normal.

The liquid employed by the mouth is best boiled and cooled to the proper temperature. The water used for irrigation should also be carefully sterilized and a small quantity (15 to a quart) of salt added. It should be used at a temperature of about 102°, and can be applied to all morbid states of the bowels very easily by an irrigating tube, œsophageal tube, or a

soft rubber catheter of large calibre attached to the syringe. Plain water or starch water to the amount of a quart, or even a gallon, should be introduced carefully but unhesitatingly until the return water is clear. At a fall of only eight inches the fluid may be expected to reach even into the small intestines in three-fourths of all cases under a year. Moreover, the advisability of intestinal feeding is suggested and should not be overlooked.

On a plane with the prompt removal of every source of internal irritation in the treatment of diarrhœa and indigestion is, of course, the prophylactic supervision of the food. Without desiring to open up the vast subject of infant feeding in this paper, the intermediate step between the regimen of water and the child's customary diet is essential to final success. After a day of "starvation"—that greatest monster of the indulgent parents' dreams—the patient should be supported on toast-water, made by pouring on stale bread, well toasted on both sides, boiling water sufficient to cover it and adding a pinch of salt, allowing it to cool, and pouring it off. Equally efficacious are albumen-water, barley or rice-water. These should be employed exclusively for at least three days, in severe cases. The albumen-water consists of the whites of eggs added to ice-water by stirring, not beating, and with a pinch of salt added, or sugar of milk, if necessary, to compromise. The barley-water is made by boiling a tablespoonful of washed pearl barley in a saucepan with a pint of water, boiling slowly down to $\frac{2}{3}$ of a pint, and straining. These drinks should be given cold, and two or three tablespoonfuls can be given every hour or two for several days, when necessary.

On returning to the patient's former habits and food, we wish, in conclusion, merely to draw attention to the experience that zealous parents and conscientious advisers are good to a fault, and too often rickets is invited, and indigestion is engrafted on many an innocent.

Carefully sterilized food is ignored *in toto*.

GRAVES' DISEASE WITH BRACHYCARDIA.—A woman suffering from Graves' disease presented marked atrophy of the thyroid gland, with certain symptoms suggesting myxœdema. There was marked proptosis, slowness of speech and sensitiveness to cold; the hands were tremulous and the skin moist; the pulse-rate had fallen to between 40 to 50 per minute. Thyroid extract had aggravated the symptoms.—Pasteur, *British Medical Journal*, May 7, 1898.

THE GENIUS OF SEPIA.

BY C. S. SCHWENK, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society, State of Pa., Pittsburgh, September 29, 1898.)

IN writing this paper it is not intended to give a detailed description of sepia. That was done by Hahnemann and has not been improved upon since, but has been strengthened by clinical corroboration.

However, when confronted by the delineation of a remedy having about two thousand symptoms in its composition, the task of moulding it into practical working shape is not a sinecure.

All of these symptoms must be carefully considered, and from what, upon first reading, seems but chaos, gradually arises the framework of the remedy, its genius, which we find present wherever sepia is demanded by disease.

One word will describe sepia: *Relaxation*. We see it in the pot-bellied mother; the prolapsed uterus; the prolapsed rectum; the patient who is puffed and flabby; *venous congestion*; and it is upon this last condition that all the important symptoms of sepia depend.

Portal stasis; heavy, sluggish liver; yellow, dirty, yellow-brown blotched skin; limbs heavy as if paralyzed; worse after sleep; and a characteristic of sepia is: worse after sleep, since sleep allows of still greater relaxation. The sepia patient must have his head high on pillows to facilitate venous circulation and gain sleep, otherwise his head gets uncomfortably full and causes anxiety. Anxiety is found present in all sepia patients.

Sphincters are weak, bowel and bladder evacuations are sluggish. Joints are weak and relaxed even to dislocation.

The sensation of emptiness and goneness in the epigastrium is one of the cardinal points of sepia, having its foundation in venous stasis.

The sepia patient is weak, seemingly debilitated, nervous; head jerks backward and forward; sensitive to noise and disturbances, which irritate her. She cries a great deal, and is much depressed, anxious and melancholy.

Pulsatilla here stands very close to sepia. Both cry very much, and they will tell you that the tears will run down their cheeks without their having anything to cry about; tears fill their eyes while talking about it; both have morning sickness and nausea upon smelling the cooking of food. But here is the difference: the pulsatilla patient is tearful, mild, affectionate, yielding and clinging; while the sepia patient may do just as much crying, she is irritable, anxious, quarrelsome, scolds a great deal, and has a peculiar cold dignity about her. Don't vex the sepia patient, for if her dignity will not suffice to hold her in reserve, her abuse will be limited only by her vocabulary.

The sepia patient is better by exercise. Why? Because exercise, such as walking, and even violent exercise, favors the return of blood to the heart, relieving the venous engorgement upon which the sepia symptoms depend.

The prolapsed uterus would naturally be intensified by walking. Jerky motions, such as horseback riding or jolting over rough roads, will also intensify sepia symptoms. The faint, exhausted condition is also a state beyond the redeeming influence of exercise, as well as the headache, which is improved by rest in a quiet, dark room, away from light.

The sepia patient is worse in the morning because of the relaxing influence of sleep, and worse in the evening from the exhaustion of the day's work, with its attending relaxations and engorgements.

The discharges of sepia are mostly irritating, causing itching and burning.

Another part of the genius of sepia is the expenditure of more force and exertion than is necessary to accomplish anything mentally or physically, showing the unconscious recognition on the part of the patient of the fact that she is at her best when actively engaged, thoroughly aroused, and with her circulation in an active state.

There is purposely a manifest paucity of symptoms in this humble description of such a large remedy as sepia, but it gives the genius of the drug, and wherever sepia may be called for this genius will be present, furnishing the key for the correct understanding and memorizing of the symptomatology.

The following extracts from different therapeutics, showing the application of sepia to different affections by men re-

nowned for their knowledge of materia medica, illustrate the dominating presence of the genius of sepia in each instance:

Functional Derangement of Liver, by Lilienthal.—"Constant aching pain in right side of abdomen, extending, when violent, to the chest and back, with oppression of breathing, aching weight and soreness in right hypochondrium, distress and aching in right shoulder and scapula; cheeks flushed; forehead and conjunctiva yellow; irregular yellow patches on face; occipital headaches; lassitude; tongue flabby and indented; no appetite, or easily satiated; flatulence; restless sleep; urine scanty and loaded with urates; atony of connective tissue and relaxation of blood-vessels; tissue torpidity relieved by exercise, which hurries on the blood; pains in hypochondria more tolerable when patient lies on painful side; hepatic neuralgia with great depression of spirits; frequent stitches under right ribs."

Uterine Displacements—Guernsey's Obstetrics.—"Painful stiffness, apparently in the uterus. Pressing in the uterus, oppressing the breathing; sensation as if everything would come out of the vagina; she had to cross her limbs to prevent it. Prolapsus of the vagina and uterus. Sensation of weight in the anus, not relieved by an evacuation. Great sense of emptiness at the pit of stomach. The urine deposits a clay-like sediment, which is difficult to remove from the chamber. Menses too late."

Vertigo, by Raue.—"Dyspepsia; venous hyperæmia in abdomen; constipation; flatulency; gradual development of amenorrhœa; hypochondriasis; climaxis, with flushes of heat and sweat; sleeplessness. Worse when drinking. Brought on by mental overexertion; excess in venery."

Diarrhœa, by Bell and Laird.—"Green, mucous; green, slimy mucous; jelly-like; bloody. Almost constant oozing from the anus. Expelled quickly; frequent; not profuse. Fetid; sour; putrid.

"Aggravation: after taking boiled milk; during dentition; in children; after taking meat; after eating potatoes; during pregnancy.

"Before stool: nausea; colic.

"During stool: prolapsus ani; jerking pains from anus upward through the rectum.

"After stool: exhaustion; debility; prolapsus ani.

“Accompaniments: jerking of the head backward and forward. Fontanelles open. Face pale or sallow; sunken, yellow about the mouth and yellow saddle across the nose. Eyes sunken. Bad smell from the mouth. Aphthæ. Tongue coated white. Putrid or sour taste. Food tastes too salt. Aversion to meat and milk. Thirst in the morning. Sour or fetid eructations. Nausea. Vomiting. Discharge of much offensive flatus. Gone feeling in the stomach, not relieved by eating. Involuntary urination at night in first sleep. Urine turbid, offensive, with reddish or clay-colored sediment, adhering closely to the vessel. Palms of hands and soles of feet burning hot. Sleepiness in the daytime. Frequent waking at night. Waking at three in the morning and inability to fall asleep again. Rapid exhaustion and emaciation.”

From the foregoing extracts it will be readily seen that the different authors embodied the genius of the drug in all their prescriptions; in fact, they could not make a correct selection of sepia or any other remedy and avoid its genius.

We often hear that the indicated remedy failed and that it was selected by one of the best prescribers. The best prescriber was disgusted with symptom-hunting when he subsequently saw the lightning-like rapidity with which O'Hoolihan's compound in capsules acted. Never mind the outcome of the case, for it was a bad one, which rapidly grew worse. It was one that couldn't get well.

You may take a materia medica and prove by matching symptoms that sepia was the remedy; and on the same case, by the same process, you could also prove that pulsatilla, lilium tigrinum and nat. mur. were the remedies suited to the case.

You may even go further and prove that lyc., calc. ost., cocculus, kali carb., stannum, ignatia, carbo an., sarsaparilla, nicotium, oleander, ipec., thea, staphisagria, actea rac. and hydrastis would cover sepia symptoms under certain conditions; but none of these remedies can take its place, nor will they masquerade as the indicated remedy if the prescriber bases his prescriptions on the genius of a drug.

If there was more of this kind of prescribing there would be less fault found with our materia medica; less criticism in the direction of useless symptoms in our materia medica, and there would be unison in the homœopathic school and an *esprit de corps* that does not exist at the present time.

We could then, with irresistible strength, place our system of medicine in the army and navy, and in the public institutions that are to-day ruled by allopathy. Results would be produced compelling recognition from every source. But we will remain just where we are, and even retrogress, so long as we prescribe for our patients at the dictation of wholesale druggists, and have men in our school and in our societies, paradoxical as it may seem, who ridicule the very system of medicine which they profess to practice.

Keynotes are useful if the prescriber has firmly fixed in his mind the genius of the remedy demanded, but without that they become a sort of bucket-shop flyer, more often missing than hitting.

The attempt to fit a remedy to any given case of sickness by matching symptoms is one of the most certain methods of leading to failure, and at the same time, unfortunately, creating in the mind of the physician the firm conviction that the indicated remedy failed. Relief must be obtained, and the anxiety upon the part of the physician to possess this jewel may be dominated by feelings of pity, or he may be influenced by the nightmare of a successor with the almighty dollar as a grand and ennobling principle stimulating him to steer his shallow craft into the eddies of palliation only to stave off the inevitable rush of disease in its natural channel, where, with failing strength, through loss of valuable time, smooth water is not always reached.

Of course, by the natural order of things, the remedy must be blamed while the physician poses in the demulcent light of destiny, shed by a divinity directing events; and as the curtain falls we sometimes imagine we see the shadows of asinine qualifications projected upon it as a vision of what might have been the cause.

A HARD PILL AND WHAT IT DID.—Prof. Binz, of Bonn, Germany, in an article on the mistakes of physicians in prescribing drugs, refers to a case cited by Prof. Kobert, of Dorpat, Russia, where a hard pill was taken by a patient, with the unfortunate result that it got into his vermiform appendix, producing an attack of appendicitis which ended fatally.—*Wiener Medizinische Presse*, No. 38, 1898.

EDITORIAL.

WM. H. BIGLER, A.M., M.D.

WM. W. VAN BAUN, M.D.

A DANGER FROM TOO MUCH ASEPSIS.

ALTHOUGH in therapeutics the actual advances made under the domination of the germ theory of the cause of disease have been insignificant, almost nil, yet it is impossible to refuse to recognize the benefits which have accrued in prophylaxis and in the surgical treatment of disease through the application of the principles of asepsis and antiseptis, based upon this theory.

In view of the great good accomplished, one is inclined to look with leniency upon the inconsistencies, illogical assumptions and contradictory observations so often offered by its enthusiastic advocates for our acceptance. We feel that there is some link wanting either in the life-history of the germ or in the reactionary activity of the organism which must be supplied before the truth of the theory can be regarded as demonstrated beyond doubt or cavil.

Taking it as it is, with all its wonderful possibilities fully appreciated, we are inclined at times to doubt the real benefit of many of its applications, nay, even at times to see how a possible harm may in the future result from them to the race, especially in the direction of too rigid asepsis in its application to prophylaxis.

We know from the history of evolution that whereas in one sense it is true that necessity knows no law, it is equally true in another that necessity is the only law governing evolution in carrying out the sole object of nature, the preservation of the species. The necessities of the environment in the struggle for existence have governed the evolution of functions, and structures for the exercise of these functions. We know, too, that by use the activity of the function of an organ becomes perfected, whereas by disuse it loses its capability, and its organ not only ceases to develop, but eventually retrogrades, and, as it were, returns to its original undifferentiated condition. The gradual development of our complicated digestive apparatus

and the present progressive passing away of our last grinders (misnamed the "wisdom teeth"), since the cooking of our food has rendered them superfluous, are familiar cases in point. It would be an interesting subject for a postprandial daydream to imagine the varying changes and ultimate fate of our digestive organs in general if the present rage for artificial digestives and for predigested foods should continue. Surely their occupation would be gone, and they could sink into an inglorious but innocuous desuetude, while a rubber bag and a hypodermic syringe could act as efficient substitutes. In the first the food could be placed for digestion under the most favorable conditions, and with the latter could be injected with elegance and precision, into the blood-current, the products of digestion.

It is universally acknowledged that the blood and some of the other fluids of the body normally possess germicidal powers, and the development of serum therapy has proved that these are capable of being reinforced up to the point of conferring immunity to certain diseases. In other words, the natural power of self-protection is strengthened by being called into exercise to such a degree as to enable it to resist all attacks. Here is done, in a comparatively short time, and artificially, what nature does at her leisure.

In the opposite procedure lies, we think, the danger of the aseptic movement, using the term in its widest sense. In our endeavor to protect the individual from the attacks of the invading germs by the destruction of these latter we render unnecessary any exertion of the germicidal function of the organism, and thereby weaken its power. A long continuance of such a course, according to what we have said above, will slowly but surely lead to an abolition of the function, and finally to a disappearance of the structures destined for its performance. This must be the inevitable result, for if capabilities are hereditary, the absence of them is no less hereditary.

To illustrate, we maintain that by using sterilized or pasteurized milk, except in cases where the powers of the organism have proved themselves to be congenitally too feeble to react, we allow an important faculty or power to lie dormant, and we will find that such children will continue to require constant excessive care to guard them against dangers which it was nature's intention they should learn to resist, and not run from.

What is the maternal "coddling" against which most of us so determinately set our faces but an unprofessional, and therefore, of course, unscientific way of doing that which we are guilty of in our excessive prophylactic efforts? It is manifestly impossible to suppress the omnipresent germ, and therefore it seems to us more rational to direct our supremest efforts to developing the powers of resistance in the individual by well selected measures, hygienic and medical. Herein lies the highest art of the physician, and herein is shown his true skill.

The virulence and fatality which attend a disease introduced into a community for the first time are matters of medical history, as well as the fact that such diseases ultimately lose much of their power as the function of self-protection or immunizing is called into play by their continued prevalence. The terrible ravages of measles and of syphilis among certain uncivilized races, when first introduced by the civilized whites, form an interesting contrast, in this connection, to the general character of these diseases as found in our midst, where familiarity has almost bred contempt.

We can hardly suppose that the discovery at this late day of the various germs which are now believed to be the causes of disease in any way implies that they did not previously exist, or that they were not in the past either potentially or actually capable of causing disease. Is it any wonder that the lay mind, looking back to an ancestry blessed with as long and as healthful lives as their own promise to be, should fail to comprehend the necessity of the various constantly increasing restrictions, cautions, and hygienic regulations whereby they feel that their personal liberty is being unwarrantedly restricted? We do not wonder at it, and from our present point of view we cannot but think that their animadversions are, in a measure, justifiable. We think it is a point open to very serious question whether the present generation is more robust than, or even as robust as, the last, or whether there is any less sickness now than then. Making all due allowance for the number of invalids conjured into existence by the rapid growth of specialism, the increase in the number of physicians, out of proportion to the increase of population, seems to point to the fact that the total amount of sickness is not materially diminished. Is the race as a whole becoming any more healthy or any less liable to disease?

We see no evidences of it. We may be able by statistics to show that a larger number of infants are floated through the dangers of the second summer on sterilized, pasteurized or modified milk, but how many of these survive to become robust adults? We may be able to show by life insurance tables that the duration of life is, on the average, a little longer, but that proves nothing as to the kind of lives preserved. Nature works on the masses, ruthlessly disregarding the individual units, whose only chance of happiness at her hands lies in their conformity to her laws for the whole; we, on account of our limited power, seek first the good of the individual and through him that of the mass, but, in doing so, we would do well to be guided in our efforts by natural laws. Our efforts are too often spent on laboriously aiding the survival of the unfittest by artificial means; we had better direct them to rendering as many as possible fit to survive.

DOES CARCINOMA DEVELOP IN THE SCAR OF AN OLD GASTRIC ULCER?—

This has seemed to me to be an interesting and important feature of those cases where, with a history that at one time pointed to an ulcer of the stomach, and where, still later, symptoms and signs of carcinoma of that organ were developed, whether a malignant growth may start in the scar-tissue of the old ulcer. The literature that I have read goes to prove that this is not the rule. Prof. Koerte, of Berlin, reports such a case to the Berlin Surgical Society. A woman of thirty-seven years, who for several years suffered from stomach trouble, for three weeks had been complaining of vomiting sour mucus, with violent pains, yet never of any blood. She was very much emaciated. A resistance of the size of a fifty-cent piece could be made out between the xyphoid cartilage and the umbilicus, which was very painful. Lower boundary of the stomach between the symphysis and the navel. The tumor was palpable immediately under the abdominal walls. Free hydrochloric acid with traces of hydrochloric acid in the stomach-contents; but slight gastric stagnation. A probable diagnosis of ulcer of the stomach with perigastritis was made and a cœliotomy done. At the upper curvature, slightly towards the pyloric end, a thickening of the gastric wall, with a turbid serous layer and fresh granulations, were found. An ulcer could be felt through the stomach with wall-like indurated and elevated edges. A malignant growth being feared, an oblique resection of the stomach, with a double row of silk sutures, was done. The excised piece measured twelve cms. on the greater and five and a half on the lesser curvature. An uneventful recovery followed. The functions of the stomach became wholly normal, and the patient gained twelve pounds. Macroscopically the specimen seemed to be an ulcer, but microscopically it was discovered to be an *adenocarcinoma*, probably developing on the basis of the old ulcer.—*Deutsche Medicinische Wochenschrift*, No. 25, 1898.

GLEANINGS.

A CASE OF GONORRHOEAL ENDOCARDITIS.—Dr. Siegheim, of Berlin, after referring to the cases of gonorrhœic endocarditis, reports one where a woman, suffering from leucorrhœa, was suddenly seized with pains in the bowels and vomiting, to which daily chills were soon added. Her lungs were normal; her heart presented a systolic murmur, her pulse quite accelerated. In a few days the area of heart dullness extended toward the right, with arrhythmia and a diastolic murmur and enlargement of the spleen. With augmentation of the dyspnœa, and complication with cystitis and nephritis, death occurred after five weeks. The necropsy revealed an ulcerative endocarditis of the aortic valves, nephritis, endometritis and cystitis. The blood drawn during life contained no bacilli, nor did that removed under aseptic precautions from the interior of the heart and stab-cultures from the vegetations on the cardiac valves. On the contrary, microscopic examination revealed diplococci lying in the cells which were decolored after Gram, as well as with alcohol and with oil of lavender. This condition in question was a true gonococcic endocarditis, which was followed by an ulcerous endocarditis without the joints being first involved. Curiously enough, with the beginning of the endocarditis the purulent discharge almost ceased, to commence again later, in all strength—a phenomenon which has often been noticed.—*Muenchener Medicinische Wochenschrift*, No. 37, 1898.

ARTERIO-SCLEROSIS; ITS CLINICAL PICTURE AND TREATMENT.—Prof. Runeberg, at the last meeting of the Northern Congress for Internal Medicine in Christiania, in the discussion on arterio-sclerosis dwelt on the clinical side and set forth three types:

1. Limited, local sclerosis. This is nearly always due to syphilis, and predominantly localizes in the cerebral arteries or the aorta. Death is prone to take place either by apoplexy or from cardiac paralysis.

2. Granular atrophy, characterized by a diffuse sclerosis of the fine and moderate-sized vessels. Signs of augmented blood-pressure set in early, with cardiac hypertrophy. Later, phenomena of insufficiency of the heart occur with renal symptoms, as albuminuria, uræmia, etc.

3. Senile arterio-sclerosis depends upon injurious influences which in the course of life have acted on the blood-vessels, so that fatty degeneration has taken place at various places. Calcification is especially pronounced in this form, and sclerosis is noted in the large and moderate-sized vessels. Clinically, there were signs of heart-incompetency with cerebral symptoms, especially delirium. On account of the poor state of nutrition cardiac hypertrophy hardly ever develops. The termination is marasmus and death.

As to treatment in the syphilitic variety, specific remedies; in the others, appropriate diet, slight exercise, exclusion of over-exertion. Prolonged treatment with the iodides is of special benefit.—*Hospitaltidende*, No. 36, 1898.

TREATMENT OF DISEASES BY CONCENTRATED CHEMICAL RAYS OF LIGHT.—Dr. Niels R. Finsen, of Copenhagen, Denmark, has erected in that city an institute devoted to the treatment of various diseases by means of concentrated chemical rays of light, using either the direct sunlight or the electric light. The writer has several times, in Scandinavian journals, called attention to the influence which the violet, blue and ultra-violet rays exercise upon the organism both of men and animals, and especially in the treatment of small-pox, where by filtering the daylight through red glass he has been able to prevent suppuration of the pustules, the consequent fever of suppuration, pitting, and the frequent sequela.

The influence of light on micro-organisms is a well-recognized fact, and proceeding from this base he has employed various collecting apparatus, with corresponding lenses, to concentrate both daylight and electric light. From exposure of cultures of various germs he finds, by these methods, that a powerful action is exercised upon micro-organisms. The blood, however, acts as a mighty hindrance to the penetration of the rays into the body, yet by pressure this may be somewhat eliminated. He presents his results in the treatment of lupus vulgaris particularly. Up to now he has treated fifty-nine cases of this disease, varying in duration between two and forty-two years, and as to extent of disease very greatly. All have been greatly ameliorated; twenty-three have been cured, apparently, and thirty are still under treatment. Only one was unaffected. Some of these latter are so well on the way to restoration of health that a cure is only a question of time. The method is unfortunately slow, for three or four months may be necessary before visible results are noticeable. This may be obviated by using a stronger light and larger rock-crystal lenses. The plates of his patients, as seen before and after treatment, do exhibit marvelous results in this very obstinate disease.—*Om Anvendelsen I Medicinen af Koncentrerede Kemiske Lysstråler* of Niels R. Finsen. Kjøbenhavn. 52pp. (Denmark.)

THE VARIOUS FORMS OF ALBUMINURIA IN DIABETES.—Dr. K. Grube, at the last meeting of the Congress for Internal Medicine, communicated his observations on the different forms of albuminuria in diabetics. Out of four hundred and seventy-three cases, three hundred and forty-seven males and one hundred and twenty six females, thirty-six were of the grave and four hundred and thirty-seven of the mild form, who were treated by the writer for four years. There was albumin in the urine in one hundred and ninety-one (40.4 per cent.). Of these, one hundred and forty were males and fifty-one females; twenty-one were of the grave and one hundred of the light variety. There are three chief factors, etiologically, of moment in the production of the albuminuria in diabetes: arterio-sclerosis, 20.4 per cent., gout, 5.2 per cent., and alcoholism, which is one of the most important, especially explaining the predominance in males. He distinguishes five forms of diabetic albuminuria: 1. Grave forms of saccharine diabetes, very frequently complicated with albuminuria. Out of thirty-six cases he met with it in twenty-one (58.3 per cent.). This is due to glycogenous or hyaline degeneration of Henle's loops. The quantity of albumin was not particularly great, but it often increases moderately before death. 2. Albumin in the urine may be dependent upon a weakening of the heart's activity—*Stauungsalbuminurie*—which is diagnosed by associated phenomena: dyspnoea, dropsy, etc. In

such cases the heart's action should be strengthened by rest in bed, digitalis, etc. 3. Senile changes in the kidneys—senile albuminuria—may be at the bottom of these cases, from sclerosis of the small renal vessels. Then present in small quantity, it may be observed in the urine at certain times, for example, after supper. Irritating substances should be excluded from the dietary. 4. Continued excretion of sugar may give rise to traces of albumin in the urine. Diminution of the quantity of sugar excreted is here indicated; then the albumin generally rapidly disappears from the urine. Such cases he regards as varieties of functional albuminuria. 5. Finally, albuminuria may be dependent upon continuation of the kidney disease. Contrary to Frerichs, and with Senator, he looks upon diabetes as *one* of the causes of kidney disease. Of one hundred and ninety-one cases of diabetes there was Bright's disease associated in forty-four. Of these, five suffered from gout, seventeen from alcoholism, and in twenty-two there was no other cause to which to attribute the renal inflammation except saccharine diabetes. The continuous passage of quantities of sugar through the kidneys ends by irritating the epithelia, bringing about "functional" albuminuria, and finally affecting the parenchyma, with alterations and increase of the interstitial tissue. Treatment should be directed towards decreasing the quantity of sugar excreted. With treatment of the complicated Bright's disease the original malady should not be forgotten nor aggravated. In general the prognosis is very grave. Milk, mineral waters, particularly of Neuenaha, warm baths, rest in bed for some time and removal of all things that irritate the kidneys.—Vrach, *Iz tekuschtschei petchati*, No. 35, 1898.

HEART DISEASE FROM IMMODERATE LAUGHING.—Dr. L. Feilchenfeld, of Berlin, was called to a young girl who immediately after a spell of loud and immoderate laughing developed a state resembling an angina pectoris, with which there was transitory enlargement of the heart's area, augmentation of the second pulmonary sound and a systolic murmur. These gradually retrogressed within fourteen days. Several others followed, but at gradually decreasing and lengthening intervals, finally wholly to disappear after about a year. The condition was ascribed to an irritation and paresis of the vagus nerve in consequence of the spasmodic activity of the diaphragm. Prof. Senator, who saw the patient in consultation, advised small doses of phenacetin. This drug seemed to have a beneficial influence.—*Deutsche Medicinische Wochenschrift*, No. 29, 1898.

ON THE CAUSATION OF PERNICIOUS ANÆMIA.—Prof. E. Grawitz, of Berlin, in a recent paper read before the Hufeland Medical Society of that city, emphasized the fact that pernicious anæmia is no longer regarded as a disease by itself, but as a *syndrom*. But to diagnose from the microscopic appearance of the blood is an impossibility, as *other grave forms of anæmia present the same degree of poikilocytosis*: irregular, large, small and crippled forms of the red blood-corpuscles. The number of the corpuscles is *greatly* reduced, so that if centrifuged they form possibly only 10 per cent. of the mass. Megaloblasts, if absent, do not point necessarily to a favorable immediate prognosis. Ehrlich looks on their presence as particularly ominous prognostically. The blood of anæmia from consuming diseases, as in extreme anæmia of tuberculosis, appears to be an atrophy *in toto*. In these simple oligæmias there is probably no specific irritation of the hæmatopoietic organs. One important feature is ever present in pernicious anæmia: the serum itself is ap-

parently normal, while in certain anæmias, as those following repeated hæmorrhages, serious infectious diseases, especially sepsis, chronic suppurations, malaria, osteomyelitis, carcinosis, chronic liver diseases, contracted kidney, osteosarcoma, and, finally, those depending on infection with the parasites, the *dochmius* and *bothriocephalus*, particularly in cancer and sepsis, the serum is decidedly thinner, though histologically the blood-corpuscles present the same conditions. Clinically, these cases are different from pernicious anæmia. Examination of the blood will not diagnose such cases, but only a continuous observation of the patient. These anæmias may lead to true, progressive pernicious anæmia. In those cases where the formation of the blood is faulty a true pernicious anæmia is present.

The ætiology is by no means simple. In examining such patients a careful and detailed search into the habits of the daily life of the patient is of the greatest importance therapeutically.—*Berliner Klinische Wochenschrift*, No. 32, 1898.

GROUP OF STATES PREDISPOSING TO PERNICIOUS ANÆMIA.—Prof. Gra-
witz, in continuing his paper, calls attention to these important conditions which may lead up to this disease :

1. Disturbances of Digestion.—In a large number of cases digestive disturbances extending over a long number of years lie at the bottom, and particularly coprostasis, in women. In some there is a true atrophy of the glands of the stomach and bowels.

2. Pregnancy.—This feature has been emphasized in earlier years. He has observed no cases.

3. Chronic Hæmorrhages.—In some individuals long repeated but slight hæmorrhages lead to this affection, in that if they be not vigorous a point is reached where the blood-forming organs are unable to make good the deficiency and undergo degenerative changes, the losses continue, and the progressive character of the resultant disease continues.

4. Constitutional Syphilis.—A very important cause. Chronic sclerotic alterations in the bone-marrow from this syphilis as well as from osteomyelitis, sarcoma and other bone-diseases, have caused pernicious anæmia.

5. Unhygienic Conditions.—These very often cause pernicious anæmia, especially in women of the lower classes, who work hard and are insufficiently fed. In the higher classes the causes are usually psychic, where women apply themselves intensely mentally and with no regard to their corporeal condition, as in menstruation. Other general exhaustive conditions, as frequent pregnancies, too long nursing, etc., come under this head.

Pernicious anæmia based on old syphilis is particularly unfavorable in its prognosis.

The nervous system as well as the blood is involved in certain cases, for persons have been observed who, after a railroad accident, a trauma or a grave psychic alteration, have developed pernicious anæmia.

6. Chronic Poisoning.—Chronic poisoning with carbonic oxide gas in one case was observed. Morphine and lead have given rise to a clinical picture like this form of anæmia.

7. Tape-worms and Intestinal Parasites.—These, especially the *bothriocephalus latus* and the *anchylostomum duodeni*, have been known to cause anæmia, and yet in some cases the disease progressed in spite of the parasites having been expelled.—*Ibidem*.

TREATMENT OF SEBORRHOIC ECZEMA IN INFANTS.—Prof. Marfan of Paris, in treatment of seborrhœic eczema of nurselings and infants advises regulation of the diet, which is usually in these cases in excess of the child's needs and treatment of the alimentary tract. Every fifteen days place the child on a thin diet, and administer every half hour 0.01–0.02 of calomel until four have been given. Locally he uses a watery solution of picric acid, 1-100, particularly in the acute and subacute forms. One may commence with poultices of boiled starch to which a little picric acid has been added, and, after the crusts have been loosened, one may apply a 1 per cent. solution of the acid, covering the head with a layer of dry cotton. As soon as the red and oozing surfaces are drier and less red then apply an ointment of the oxide of zinc.—*La Settimana Medica*, No. 39, 1898.

MASKED FORMS OF ABDOMINAL CANCER.—Dr. S. Levaschoff records four cases of abdominal cancer which developed in an unusual manner, the last two of which are of particular interest. A man of seventy, formerly in perfect health, was suddenly seized with violent pains in his abdomen. Examination revealed no appreciable lesion: appetite, temperature, digestion and urine were normal. The pain was chiefly localized in the right hypochondrium, and though the liver was not sensitive to pressure at the angle of the false ribs and the quadratus lumborum, a tolerably firm pressure was painful. The pain, at first controlled by codeine, soon required hypodermics of morphine. In a month the patient had become slightly cachectic, and in three months the left-sided inguinal and supra-clavicular lymph-glands were enlarged—a symptom of undoubted pathognomic value in the diagnosis of cancer. Great anorexia set in, and seven months after the first appearance of the pains the man succumbed from progressive heart failure, with œdema of the lungs. No necropsy.

The second case, an obese woman of sixty-five, was, suddenly and without apparent cause, seized with pains in the right lumbar region, which increased progressively in intensity, and which were dull, continuous, with paroxysmal exacerbations; they remained in the same location, were aggravated by deep breathing and by bending forward, but not on pressure. The thoracic and abdominal viscera as well as the urine were normal. A few weeks later there was a moderate elevation of temperature, and beneath the right scapula an area of dullness, with friction sounds, was detected. Simultaneously the lumbar pains aggravated, so as to resist codeine. The patient became gradually weaker and died six months after the beginning of her illness, yet without offering any palpable signs of an abdominal affection. Though no necropsy was allowed, he thinks that there is no doubt of her having had a cancer of the retro-peritoneal glands, with advance of the neoplasm through the diaphragm and production of a pleuritic patch. From observation of five similar cases he sets forth a neuralgic form of abdominal cancer characterized especially by the element pain, with possible exclusion of hepatic and nephretic colic, lesions of the central nervous system, palpable affections of the thorax and abdomen, exclusion of renal diseases, and uninfluenced either by periods of the day or the taking of food, but with spontaneous exacerbations and remissions. Later the lymph-glands swell, though this may be absent. Noticeable emaciation follows rapidly, and the patient succumbs after eight to fourteen months.—*Vratch.*, Aug. 29 and Sept. 5, 1898.

FRANK H. PRITCHARD, M.D.

AMPUTATION AT THE HIP JOINT.—So unsatisfactory have been the results of this operation that there are fully fifty recorded methods of performing it. Amputation at the hip was not long since termed the most formidable a surgeon could be called upon to perform, yet to-day the old-time mortality of nearly 100 per cent. has been so reduced that the operation can now be classed with the major amputations of the extremities. This is mostly due to the fact that it has been made practically as bloodless as an amputation through the balance of the limb. The credit of perfecting the application of the Esmarch principle to the hip belongs to Wyeth, and from the statistics he has collected, taking into account the improvement in wound treatment, perfected hemostasis is credited with an improvement of about 60 per cent. The essential feature of Wyeth's procedure is the support given to the Esmarch constrictor by heavy mattress pins. These should be about a foot long and one-fourth of an inch thick. One pin is entered immediately below and outside of the anterior superior spine of the ilium, and is pushed downward through the tissues, passing close above the great trochanter. The second pin is introduced inside the vessels just below the crotch, and passes through the adductors, coming out an inch below the tuberosity of the ischium. An Esmarch band is tightly wrapped five or six times around the limb above the pins. In an emergency the outer pin alone has held the tourniquet, or two or more loops of bandage have been passed under the tubing, and by drawing them firmly upward it has been held in place. The incision recommended is a circular one, about six inches below the constrictor, and is carried down to the muscles. This has, more recently, been supplemented by a vertical one from the trochanter down. The femur should be disarticulated before the bone is sawn through. The principal vessels are readily recognized and tied. An important life-saving factor in connection with this operation is the co-operative infusion of normal salt solution. Some surgeons go so far as to advise the exposure of a vein at the bend of the elbow preliminary to the operation.

Four cases have been operated at the Hahnemann Hospital by the writer—two for sarcoma, one for epithelioma and one for extensive infection—and all were immediately successful; a fifth, who had an infected compound comminuted fracture of the femur, passed through the first step of the operation (two tempo), but died of shock a few days later after another operator had completed the disarticulation.—Dr. Wm. B. Van Lenep in the *Medical Century*, October, 1898.

F. WALTER BRIERLY, M.D.

DESULTORY REMARKS ON FEMORAL HERNIA.—I would say that, as regards the frequency of femoral hernia, my experience does not correspond with the generally accepted statistics. Of some 150 operations for groin ruptures, over 30 have been below Poupart's ligament. I find but 4 per cent. of female inguinal and only two instances of male femoral hernia in all cases observed.

The proportion of strangulated femoral herniæ has been larger in my practice than inguinal.

The mechanical and non-operative treatment of the average femoral hernia is not as satisfactory as that of the inguinal variety.

We are supposed to distinguish an enlarged gland by its mobility and by recognizing that it does not enter the femoral canal; also by the fact that such a tumor is lobulated; and yet I have several times met with the not uncommon hypertrophy of the extra-peritoneal fat—the lipoma herniaire of the French—

which fulfilled these requirements in every particular, but under which was concealed an intestinal knuckle.

Another source of error, less frequent but worthy of mention, is due to the almost constant adhesions of the extruded omentum which permits the encysting of fluid from various traumatisms.

Psoas abscess also presents diagnostic difficulties ; of course, in the average case pelvic examination, rectal or vaginal, will show an intra-abdominal continuity, while the lump is not reducible.

While of minor importance, the distinction between inguinal bubonocoele and crural hernia may be a difficult task. In a certain number of cases, particularly when strangulated, the upward curl over the falciform process obscures the variety.

It is worth while to remember that only too often we have but the skin, the tremendously emaciated fascia propria and an equally insignificant peritonæum, so that it is possible by the first cut of the knife to wound the intestine. Equally deceptive, although less dangerous, is the presence of the lipoma herniarie, which gives the impression that the operator is already within the sac and in contact with the omentum.

I have found truss treatment, with the most careful attention and repeated adjustment, to be much less satisfactory than in inguinal hernia. Crural hernia, too, can never be cured by the pressure of a truss.

In femoral hernia, on account of the close proximity of the vessel, there is little chance for the use of the injection treatment by those who believe in and practice it.

Taxis is contra-indicated in herniæ which have been irreducible previously, in those which present inflammatory symptoms, and in those in which the attack has lasted for twenty-four hours.

In the operation of Bassini we have a logical and simple method by which more herniæ are cured than by any procedures practiced in the inguinal variety.

I have used in both femoral and inguinal herniæ the different methods of treating the sac recommended from time to time—Macewen's buttress, Ball's twisting, high ligature, suture, etc. For some years I have attempted to bring about an obliteration of the intra-abdominal dimple by ligating the sac as high up as possible, and by transplanting the stump above the inguinal canal inside of the abdominal wall. This can be done very readily by drawing up the skin and superficial fascia, threading the ends of the sac ligature, which are left long, on a needle, and bringing them through the muscular layers from the inside and tying them on the outside.—William B. Van Lennep, M.D., *Medical Century*, September, 1898.

F. WALTER BRIERLY, M.D.

AN UNUSUAL CASE OF ABDOMINAL HÆMORRHAGE.—Dr. William B. Van Lennep reports a case of retro-abdominal hæmorrhage of unusual interest on account of its close resemblance to ectopic gestation. The patient, 36 years old, had been twice pregnant, the last confinement six years previously, and had twice miscarried; she had never required treatment for intra-pelvic disease. Early in September, 1897, she fell from her wheel, the handle-bar striking and bruising the lower abdomen. Considerable pelvic tenderness resulted, but nothing of sufficient moment to confine her to bed; nor did the

accident produce any especial prostration or fainting. At about the same time she menstruated rather profusely ; the October menses were missed, and three weeks later a metrorrhagia appeared, together with pains simulating abortion. The flow continued for ten days, when she suddenly went into profound collapse. Slight recurrences of the latter took place two and four days later, and a severe one at the end of a week. Aside from the symptoms of hæmorrhage, she suffered from agonizing, paroxysmal pain, sudden in onset and referred to the lower abdomen. Associated with this were general abdominal tenderness and distention, soon followed by pelvic and supra-pubic tumefaction, rather more marked on the left side.

A pelvic examination was made under anæsthesia immediately before the operation. The uterus was in good position and but slightly enlarged ; its cavity was empty. A median incision showed the pelvis filled with loose clots, but no changes about the uterus and adnexa beyond a few soft inflammatory adhesions. The bleeding was found to come from a rent on the outer side of the meso-colon of the upper rectum and sigmoid flexure, which was enormously distended with blood, as was the mesentery of several neighboring intestinal coils, forming a tumor as large as an adult head. The clots were evacuated as thoroughly as possible through the mesenteric rent, the cavity washed out and carefully stuffed with iodoform gauze ; this, in turn, surrounded by a protective abdominal pack, after the pelvis had been cleaned out, and the wound partly closed with sutures. The immediate effect of the operation was to bring down the temperature from 103 degrees plus to the vicinity of 100 degrees, about which it kept for nearly a month. She made a good recovery.—*North American Journal of Homœopathy*, December, 1898.

F. WALTER BRIERLY, M.D.

CÆSARIAN SECTION.—Everke has performed this operation thirty-five times, with the following fatalities : Twice for operations in mortua, twice for severe eclampsia, once from exudative pleurisy, once from exudative peritonitis complicating the operation, and in one case operated on under unfavorable conditions, *i.e.*, 14 per cent. total mortality ; and of this, 11 per cent. from sepsis. Thirty children were delivered alive. One child was delivered alive from the section in mortua, and two children were saved in two cases of eclampsia, and both mothers dying in coma. The results of Cæsarian section are not more unfavorable than those of craniotomy if the cases are operated on early. The mortality from sepsis (11 per cent.) was due to repeated examination and infection before the patients entered the hospital. He advises Cæsarian section in a good hospital rather than craniotomy on the living child ; but if the cases are seen early enough premature labor is preferable to either. Symphyseotomy is technically difficult, dangerous, and offers no certain prognosis for the child ; at the same time a woman may be incapacitated for work as a result of this operation. Three cases of atony of the uterus in women operated on previous to the beginning of uterine contraction showed the importance of delaying the operation till labor-pains have commenced actively. He uses digital compression instead of the elastic ligature. He is opposed to the transverse fundal section of the uterus, as the wound heals badly from insufficient nourishment. Good suturing of the uterus is the most important. He applies a decidual line of sutures tied toward the uterine cavity, besides deep and superficial layers tied on the peritoneal surface.—*Centralblatt für Gynakologie*, No. 41, 1898.

SUBCUTANEOUS SALINE TRANSFUSION FOR PUERPERAL FEVER.—Eberhart recommends, especially in the septic form, the transfusion of an 0.9 per cent. salt solution. It is particularly valuable if there is severe vomiting and every swallow of fluid is rejected by the stomach, and the organism is thereby becoming impoverished of its water. He uses one liter each time. It has a diuretic effect, diluting and excreting the bacteria and their toxic products, and the blood circulating in the kidney is less concentrated. Harm can never follow.—*Ibid.*

THE MECHANICAL TREATMENT OF ATONIC UTERINE HÆMORRHAGE.—Arendt calls attention to the fact that strong traction on the uterus makes it bloodless, and that a uterus well drawn down can be bisected without hæmorrhage, even in advanced pregnancy. He advises in atonic uterine hæmorrhage drawing down the cervix gradually and firmly with volsellum forceps as far as it will come, and repeating this procedure three or four times to fix the uterine contractions produced by it. These contractions are produced by the anæmia of the uterus, and chiefly by the severe mechanical irritation of the traction on the automatic ganglia cells of the middle layer, and also by the reaction of the stretched nerves in the broad ligament. This traction on the uterus can be combined with packing the uterine cavity with aseptic gauze.—*Ibid.*

A NEW AND SIMPLE STERILIZER.—Krug recommends an ordinary round metal case, with a cover which screws on tight, and large enough to hold the instruments desired for an operation. One or more of Schering's formalin pastiles is placed at some particular part of the case, which is closed tight and put in the oven of a stove, or held over a spirit flame at the site of the pastile, so as to evaporate the formalin.

The size boxes recommended are :

1. Forceps, 40 x 9 c.m. Holding forceps, long knee-elbowed scissors for incising the cervix uteri, volsellum forceps, and long dressing forceps for packing the uterus.
2. Craniotomy, 46 x 8 c.m. Contains cranioclast, cephalotribe, trephine and spear perforators, blunt and sharp hooks and bone forceps.
3. Abortion, 32 x 3.6 c.m. Holds two curettes, two volsellum forceps, placenta forceps, and cannula for packing the uterine cavity with gauze.
4. Perineal suture, 18 x 4 c.m. Needle holder, glass tubes with needles, catgut, silk-worm-gut or silk, two Péan's scissors, and razor with metal handle.
5. Cæsarian section, 9 x 4 c.m. Five Péan's double bistouries, director, needle holder and ligatures.—*Ibid.*

OPERATIVE STERILIZING OF THE FEMALE.—Rose recommends the wedge-shaped excision of the tubes from the uterus. The tube is drawn out firmly from the uterus. Three sutures are inserted beneath the little ball which appears at the drawn-out insertion of the tube. The ball is excised and the sutures tied. The operation is simple, rapid, and the muscular union obtained is more secure than any union by peritoneal adhesion. The same method is recommended in operating on gonorrhœal salpingitis, as there are no stumps to infect the peritonæum after operation, and the uterine cavity can be treated energetically and safely.—*Centralblatt für Gynäkologie*, No. 45, 1898.

GEORGE R. SOUTHWICK, M.D.

ATROPINE IN THE TREATMENT OF DISEASES OF THE EYE.—In an article by Dr. W. B. Marple (*N. Y. Polyclinic*, July 15th) the indications and contraindications for the use of atropine in eye troubles are summarized as follows:

1. It should be used in iritis.
2. It should be used in ulcer of the cornea and keratitis.
3. It may be used as a mydriatic in young persons under 30 or 35 years of age. Cocaine or homatropine, however, answer as well, and have many advantages.
4. It may be used in refractive work to relax the accommodation in the same class of patients as in "3."

Here also homatropine does well.

In regard to the contraindications we find that:

1. It should not be used in conjunctival troubles.
2. It should not be used simply to dilate the pupil in patients over 40 or 45 years of age unless iritis is present, in which case the age of the patient should not deter us from employing it.
3. It should never be used in glaucoma or where the tension of the eye is increased.

Finally, only weak solutions ($\frac{1}{4}$ of 1 per cent.) should be used in young (1 to 3 years) children, otherwise constitutional effects of the drug are apt to follow.

SOME DISTURBANCE IN THE DISTRIBUTION OF THE OCULOMOTOR NERVE FOLLOWING MEASLES.—Dreisch reports three cases of paralysis of the oculomotor nerves as a sequel to measles. The first was a boy 9 years of age, who, eleven days after recovery, noticed some difficulty in reading, which soon increased so that he was unable to read at all. Distant vision was perfect; near vision was made perfect by a convex lens of 3 D. A diagnosis was made of paralysis of accommodation, and this soon disappeared.

The second patient was a girl 8 years of age, who noticed similar symptoms three weeks after an attack of measles.

The third patient was a boy of 14, who commenced with vomiting, chills, and then diplopia. When examined he was found to have marked ptosis, incomplete paralysis of the internal, superior and inferior recti, and the inferior oblique. Recovery in three weeks.

Dreisch admits that it is impossible to say how these changes occur. He does not believe, however, that they are due to the late influence upon the nervous tissue of a toxin circulating in the blood, particularly because similar paralysis occurring in diphtheria are not prevented by injections of serum. He is inclined to locate the lesion in the peripheral nerves on account of its occasional exquisite localization to a single branch.—*Muench. Med. Wochenschr.*

A CASE OF DEATH FOLLOWING ENUCLEATION FOR PANOPHTHALMITIS.—The patient, a blacksmith, was struck in the eye by a piece of steel, which passed through the cornea, destroyed the lens and produced a hernia of the iris. Five days after the accident the eye was enucleated for commencing panophthalmitis. The next afternoon fever, which was at first supposed to be due to indigestion, set in. On the fifth day after the operation the patient died. Not until twenty-four hours before death did the condition manifest itself as a meningitis.—Periguex Delbes, *La Clinique Ophthalmologique*, July 25, 1898.

WILLIAM SPENCER, M.D.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND
THERAPEUTICS.

THE ACTION OF THE BARIUM SALTS ON THE HEART.—Hale, of Chicago, reiterates the value of the salts of baryta, the acetate, muriate and carbonate, in cardiac diseases. Their sphere, as Hahnemann was the first to announce, is in diseases of the aged. Hale finds that baryta is one of the best remedies in senile heart, where the other cardiac remedies seem to have little effect. The primary effect of barium is to stimulate the cardiac muscles and the capillary blood-vessels. Secondly it causes weakness of the heart-muscle, with flaccidity and relaxation, even to the extent of paralysis. It causes just that kind of capillary relaxation that we find in the peripheral circulation of old persons. There is one symptom, not found, however, in the pathogenesis of barium, that is characteristic. It is a sensation of "sinking emptiness or faintness in the pit of the stomach." This symptom belongs to several cardiac remedies, namely: digitalis, ignatia, veratrum alb., convallaria and cactus. It is also found in hydrastis, lachesis and caladium. But wherever this symptom is found in old people, baryta is almost specific.

It is not in diseases of the old alone that baryta is useful, however. It seems to be almost equally adapted to diseases of children, especially where the heart and blood-vessels are weak. Hare, of Philadelphia, has reported two such cases, illustrating the value of baryta.

Hale quotes at length the article of Brunton, in his *Materia Medica*, concerning barium, in which the heart effects are carefully recorded. These observations should be of great value to us.—*Medical Visitor*.

PRUNELLA, A NEW REMEDY FOR DIARRHŒA AND DYSENTERY.—According to Prof. C. B. Stayt, *Prunella vulgaris* has, in his hands, proved almost a specific for all loose evacuations. As soon as its good effects are noticed the patients will have a natural movement from the bowels.

Prunella vulgaris is a member of the mint family and is found on the plains of Illinois. Among the old botanic physicians it was known as "healing balm" and "heal all." It is mentioned in the *United States Pharmacopœia* as *brunella* or *prunella*, and is said at one time to have enjoyed a high reputation in the treatment of diarrhœa and hæmorrhage. Its activity is probably due to a form of tannin.

Dr. Stayt uses an infusion of the green plant. Doses of two or three drops of the tincture may also be given.—*Medical Visitor*.

ARSENICUM IODATUM 3X (prepared in ether) IN ENLARGED CERVICAL GLANDS, PROBABLY OF SYPHILITIC ORIGIN.—Dr. Bonino records the case of a woman of 53 years, childless, but who had aborted twice after being infected sypilitically in her thirty-seventh year. After a series of morbid manifesta-

tions, now in her bones and now on her skin, there appeared a collar of enlarged cervical glands which suppurated and corroded away the skin so that the muscles of the neck were exposed. They gave rise to intolerable burning pains and discharged an extremely stinky pus. Under the internal use of the iodide of arsenic for five months this morbid condition disappeared wholly, the skin healed over the excavations, and they filled up entirely.

CHARACTERISTICS OF SEVERAL REMEDIES.—In the Italian homœopathic journal, *Il Secolo Omiopatico*, No. 9, 1898, the characteristics of several remedies are given.

Argentum Nitricum.—Produces atony and destructive inflammation of the mucous membranes, as well as having a special action on the nervous system, determining paralysis of sensation and motion.

Arnica Montana.—Produces states similar to those resulting from shocks, falls, blows and contusions.

Arsenicum Album.—Intense irritation of the mucous membranes, violent burning, which is decidedly characteristic though not exclusively indicative of arsenic. Intense burning in the stomach (canth., nux vom., phos. and secale c.). Vomiting, after the least movement (veratr. and zinc.). The morning vomiting of drunkards (nux v.). Diarrhœa with great prostration, the stool watery and corrosive (cham., merc. and sulph.). Great alteration of the features (canth., china and veratr.). Characteristics of the drug as a whole are: (1) The periodicity; (2) the weakness and prostration; (3) the malignity of the symptoms; (4) the impossibility of remaining quiet, and the anxiety-anxious restlessness; (5) the general sensation of burning; (6) pains which aggravate from rest and cold; (7) insatiable thirst, with drinking of small quantities of water, frequently repeated.

Arum Triphyllum.—Nostrils painful and excoriated. Rawness and sensitiveness of the pharynx. Sudden change in the sound of the voice. A dry cough, which the patient fears on account of its distressfulness.

Asafetida.—It brings about a condition of the nervous system which resembles hysteria. All forms of hysteria where the throat symptoms predominate: a sensation of a lump in the throat or as if a spasm were ascending the œsophagus, producing difficulty in breathing and causing alarm about it. It also acts on the bones. Painfulness of the bones, with softening and swelling of the bone and periosteum. Periostitis. The ulcer has high, hard edges, bleeds easily, is sensitive; the discharge is profuse, greenish and offensive, with hysterical symptoms.

Asarum.—Sensation as though the body were suspended in the air. Intolerance for noises.

Aurum.—Acts on the glandular system, liver and testicles. It influences also the bones, with a remarkable control over those of the palate. Characteristics are: a disgust of life and a desire for death, with a tendency to suicide; desperation and a sense of being useless in the world; a form of religious mania in which the patient regards himself as damned.

F. MORTIMER LAWRENCE, M.D.

SECALE CORNUTUM IN TENDENCY TO ABORTION.—Dr. Lombe Atthil, of Dublin, in a recent number of the *British Medical Journal*, praises the beneficent influence that ergot exercises over the pregnant uterus where there is a tendency to abort. He claims that it is a tonic to the uterus. He employed

it in the Rotunda Hospital, of Dublin.—*Journal Belge d'Homœopathie*, vol. v., No. 4, 1898. If any one doubts that ergot will produce abortion, then let him read Jousset's article on the toxicology of that drug in *L'Art Médical*, July, 1898. The allopaths about here use the tincture of ergot in small doses for after-pains. They assert that it acts by correcting a tendency of the uterus to contract irregularly.

CASES FROM PRACTICE.—Dr. Oscar Hansen, in a case of *pains in the shoulders* radiating into the occiput at times, and rendered worse by rest and at night, where *rhus tox.* 2x, three drops three times a day, produced an aggravation, were promptly and permanently cured by *rhus* 1x, given in the same manner. A case of *hemorrhoids*, with constriction of the stomach, which was ameliorated by *hydrastis* 1 c., five drops three times a day, and locally glycerine and *hydrastis*, equal parts, morning and evening, followed by *ratanhia* 2 c., five drops three times a day, with simultaneous local use of equal parts of tincture of *ratanhia* and glycerine, morning and evening, improved, yet a cure only followed *æsculus hipp.* 2x. five drops, three times a day, with local use of the drug in a cerate. A case of *weakness of the arms*, a consequence of overwork, was promptly cured by *rhus* 1 c., three drops, three times a day.—*Journal Belge d'Homœopathie*, No. 2, vol. v., 1898.

IODIC PURPURA.—In consequence of an injection of tincture of iodine into a hydrocele the patient was attacked with albuminuria and jaundice, and eight days after the operation he was seized with a violent chill, followed by a generalized petechial eruption. A similar case has been reported by Prof. Lemoine, of Lille, France, after an injection of five cgms. of iodide of sodium.—*Journal Belge d'Homœopathie*, vol. v., No. 2, 1898.

ERGOTIN IN INVOLUNTARY DEFECATION.—Dr. Koeck, of Munich, was consulted by a railroad employé who, since the Franco-German war, had suffered from a chronic diarrhœa, but who now found it impossible to retain his stools, either by day or night, for they would pass him involuntarily. He had no sensation in his rectum of a threatening passage, so that he "*hatte die Hose immer voll.*" The stench that struck the doctor on entering the room might easily be imagined. The unfortunate man had been under old-school treatment for some time, without result. He was about to be pensioned, and had thoughts of suicide. *Secale corn.* 3x was administered, with slight amelioration; then the second dec. dil. was given, with the same result. Remembering Kafka's advice to use the alkaloid when the indicated drug does not seemingly act, he prescribed ergotin 2x. After taking the drug for four days the doctor was agreeably surprised to see him walk into his office, to report himself able to control his sphincter.—*Homœopathische Monatsblätter*, No. 9, 1898.

BELLADONNA IN HYSTERIC SPASMS.—Dr. A. Sperling was called to a young woman, who, from an old genital disease, was very nervous. On account of very sudden and joyful news she had fallen into the following condition: She lay in bed, her narrow face as pale as death, lips blue, features distorted, eyes half-open. She seemed to suffer severely from the pains which at times shot through her body. Then she would draw her legs up against her body and close her hands convulsively. The bromide of potash

in large doses had had no effect; on the contrary, her state had become aggravated in the last few hours. Bell. seemed indicated and was administered in the fifth dec. dil., five drops at a dose, to be repeated in ten minutes. In five minutes after the first dose she fell asleep, so that she had to be awakened for the second, and from then on she slept the whole night. The spasms did not recur.—*Homœopathische Monatsblätter*, No. 9, 1898.

CHARACTERISTICS OF A FEW DRUGS.—In the Homœopathic Italian journal, *Il Secolo Omiopatico*, No. 7, 1898, the following useful notes are given:

Esculus hippocastanum.—Abdominal plethora, with deep pulsation in the abdomen. Hæmorrhoids, with dryness of the rectum, as though thorns were sticking in the mucous membrane. Reddish-purple tumors, with back-ache over the kidneys.

Agaricus muscarius.—Acts chiefly upon the nervous system, upon the brain, like alcohol, with more pronounced delirium and irritation, and an accompanying increase of muscular strength. Tremor and nervous shocks (characteristic).

Aloe socotrina.—Acts principally upon the liver, yet it has many symptoms of congestion of the uterus and of the portal system. Headache in the frontal region, or a sensation of weight in the vertex. Heaviness of the eyelids and nausea. An imperious desire to evacuate the bowels of mornings, associated with a weakness of the sphincters and discharge of much gas. (Such patients are easily subject to misplaced confidence, according to Prof. Heber Smith, of Boston).

Acts upon the rectum and colon, producing a drying up of their secretions and a great depression of the cerebro-spinal system. Dryness of the mucous membrane is a characteristic symptom. The conjunctivæ, nose, intestinal canal are entirely dry.

Ambra grisea.—Acts upon the nervous system, giving rise to symptoms similar to those of hysteria. Its characteristics are absence of reaction in consequence of nervous weakness; inclination in women to constipation; cough that exacerbates during the menstrual epoch.

TREATMENT OF BLACK-WATER FEVER.—Dr. Hayward, in this variety of malaria, recommends beginning with ipecac when there is nausea. The urine is reddish or brownish, giving it every half-hour to two hours. If the urine be blackish, then phosphor., particularly with the characteristic blackish or coffee-colored color, with insatiable thirst. But if the blood appears as if dissolved in the urine and vomit, as though the red corpuscles were broken down, then crotales is the remedy. If the temperature be elevated, alternate with aconite until it fall.—*Revue Homœopathique Française*, Nos. 7, 8 and 9, 1898.

TREATMENT OF HÆMATURIA FROM LESIONS OF THE KIDNEYS.—Dr. R. Staeger, in an extensive study of "Hæmorrhages from Internal Organs and their Homœopathic Treatment," sets forth in "Hæmaturia of Renal Origin" the following remedies:

Arnica.—Indicated in hæmaturia from renal infarcts and that due to injuries of the kidneys. (In a case of injury of the kidney which I recently observed, where an elderly man of a weakly constitution was kicked out of a barn door by his horse, and where the whole force of the blow came over his

right kidney, I noticed quite bloody urine to follow. Here rest in bed, with turpentine, for one day had no effect on the quantity of blood passed. Trillium pend. ϕ , ten to twenty drops every two hours, cleared up the urine in two days. The influence of the remedy was apparent after one day, when the urine was only a little smoky.—F. H. P.)

Kali nitricum.—Recommended in chronic nephritis, with acute aggravations and uræmia.

Cantharis.—Indicated particularly in acute nephritis and retention of urine in general in inflammatory diseases of the kidneys. In such cases cantharis cures the hæmaturia, together with the original disease.

Aconitum.—Assists particularly in acute Bright's disease, appearing after scarlatina, as well as that following cold. (Goodno recommends aconite in hæmaturia when due to acute inflammatory conditions of the kidneys; also terebin. and canth.).

Cannabis sativa.—Also indicated in ordinary and acute inflammation of the kidneys. This remedy is called for in those cases with dragging pains in the region of the kidneys, running down into the inguinal glands, with a sensation of nausea and anxiety in the epigastrium.

Helleborus.—In scarlatinous nephritis, with severe general dropsy. The blood in the urine disintegrates or decomposes, so that on standing it forms a deposit at the bottom of the vessel like coffee-grounds.

Terebinthina.—Recommended in congestion of the kidneys, as well as in retention of urine. The color of the blood is dark.

Crotalus and Lachesis.—In renal hæmaturia, in consequence of diseases of the blood itself, as scorbutus, morbus Werlhoffii, yellow fever, etc.

Ipæacuanha.—Indicated in renal hæmaturia, where it does good service when the original disease is accompanied by nausea, anxiousness in the chest, and cutting pains in the bowels.

Arsenicum.—Indicated pre-eminently in chronic nephritis, appearing in connection with heart diseases and general dropsy. Great dyspnoea. Extreme thirst. The urine contains a great deal of albumin and casts. Dark and bloody urine, like a dirty serum.

Colchicum.—This remedy causes a greater degree of congestion, with mucous shreds and lumps in the urine. The urine is dark, turbid, bloody, frequently blackish, like ink, and contains albumin. Dropsy. Painful urging and tenesmus just after having urinated.

Digitalis.—This drug gives rise to venous congestion of the kidneys. It is employed in affections of the kidneys where there are simultaneously dropsy, a weak pulse, and a turbid urine, either with or without albuminuria. Digitalis resembles arsenicum, without the restlessness and the irritability.

Kali iodatum.—This drug finds its indications in contracted kidney, with its corresponding symptoms, particularly if it be either of mercurial or syphilitic origin.

Kali carbonicum and *Acid. carbolic*.—Both these remedies are indicated for and also cause dark, turbid urine, containing blood. Therefore, they are indicated in renal hæmaturia, as well as a whole series of drugs affecting the renal parenchyma.—*Vratch Gomeopat*, No. 6, 1898.

DIGITALIS IN URÆMIA.—Dr. Hesse, Hamburg, had under treatment a child of 6 years, who developed an acute Bright's disease after having passed

through an attack of scarlet fever, followed by one of diphtheria. The nephritis came on with vomiting, and, even after disappearance of the albuminuria, it still kept up until the child was threatened with death, for during fourteen days its condition had remained unchanged. Sleepy day and night, only interrupted by taking food and vomiting. It vomited all of its food and mucus six to eight times a day, with distressing and torturing strangling. Before vomiting, great anxiety and restlessness; after vomiting, great relief; no appetite; moderate thirst; the bowels were constipated; the urine was dark, turbid, with a dark sediment, and of a pungent odor; *the pulse was strikingly slow*, about fifty a minute. No remedy appeared to act, and the child grew gradually weaker. Digitalis was chosen on account of the brachycardia and somnolence, interrupted with attacks of convulsive vomiting, continuous vomiting, vomiting with great relief, ammoniacal and turbid urine (v. Boëninghausen, Jahr and Hering). The remedy was given in the tenth decimal dilution, one powder morning and evening. Already, after the first powder, a radical change set in. The next day all the symptoms except the vomiting, which recurred on the third day, had wholly disappeared. The patient asked to eat all the time, and tolerated his food well. After the fourth powder the pulse-rate was 80. The urine increased; was a pale yellow, without odor or sediment. No other treatment was necessary.—*Homœopathische Monatsblätter*, No. 10, 1898.

TREATMENT OF THE CONVULSIVE FORM OF MALARIA.—The spasms may set in under the form of tetanus, epilepsy or eclampsia.

Tetanus.—*Angustura* responds best to the tetanic form. Chill in the afternoon or at three o'clock. *Nux vom.*—If the convulsions are brought on by contact. *Ignatia.*—Convulsions of a tetanic character, with a desire to yawn.

Epilepsy.—*Nux vom.*, *hyoscyamus*, *absinth.*, are to be employed in those with an alcoholic history; *plumbum* in those very pale, subject to obstinate constipation and violent abdominal pains, especially if there be at the same time a weakness of the forearms. *Rana bufo* is one of the chief remedies of true epilepsy; in man it produces a typical attack, with foaming on the lips, biting of the tongue, retraction of the thumbs into the palms and an absolute loss of consciousness and feeling.

It also gives rise to a periodic fever of a quartan type, with a predominance of the sweating, which floods the face and is viscid and cold. Therefore this is one of the principal remedies.

Eclampsia.—*Belladonna* is indicated in that it produces all sorts of spasms of the throat, larynx, pharynx and limbs. *Dolichos pruriens*, clonic spasms of the extremities, with loss of consciousness, immobility of the eyes and eyelids, which remain open. *Tarantula*, choreic spasms, which cease on hearing music.

TREATMENT OF CHILDREN WHO LEARN TO WALK LATE.—Dr. L. Grossberger, of Bromberg, has obtained astonishingly good results in three or four weeks by the use of sulphur, 5x, in the morning, a half-hour before nursing or two hours thereafter, and then for fourteen days one dose of cal. carb., 3 x, each day, at the same time using a sitz-bath every morning.—*Leipziger Populäre Zeitschrift fuer Homœopathie*, Nos. 19 and 20, 1898.

FRANK H. PRITCHARD, M.D.

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THE PERNICIOUS VOMITING OF PREGNANCY.*

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In this article allow me to report a few interesting cases for our consideration and discussion.

Mrs. F. B., aged about 35 years; multipara; seen in consultation with Dr. Neefus, August 3, 1898. The history of the case follows:

Menstruation ceased in January and about February 15th she complained of nausea, vomiting and ptialism, which continued more or less severe for five months. In June she had a profuse hæmorrhage, which relieved the nausea and stomach symptoms. Two weeks later another attack of hæmorrhage occurred, though not so severe as before. Becoming alarmed that her form did not change as time advanced, she desired a thorough examination, which was made on the above date. The uterus was five and a half inches in depth, as ascertained by the sound, and contained a sharp flexion in the anterior wall. The product of conception was backward, and somewhat under the promontory of the sacrum, but within the uterine

* Read before the Homœopathic Medical Society of Western New York, at the meeting held in Buffalo, January 13, 1899.

cavity. The thorough examination and the possible presence of the sound (though this instrument was introduced with the greatest care) caused a miscarriage in a few days, completely emptying the uterus of a dead embryo, of about three and one-half months' development. The uterus was curetted and irrigated, owing to a rise of temperature immediately after delivery. The temperature came down at once after this operation, and she made a rapid recovery.

Mrs. H., age 22 years; primipara; her history indicates suffering from dysmenorrhœa since puberty, but she never had a vaginal examination to ascertain its cause. About July 15th the patient complained of severe nausea and vomiting, being then two and one-half months advanced in pregnancy. A digital examination disclosed a sharp anteflexion of the uterus, which apparently caused the stomach difficulty and the chronic dysmenorrhœa. For the next three weeks she lost most of her food, though it had been carefully selected. Artificial interference was then seriously considered, but as she seemed a little better, having now passed the reflex irritation incident to the menstrual period, it was postponed for the present. Being then very hot in the city, after a few days of improvement she was sent to one of the inland lakes for two weeks of change and recreation. Upon her return, August 22d, she entered the homœopathic hospital, should interference become necessary at the fourth month. Upon examination she was found much improved in health, being able to retain a large amount of her nourishment, while the uterus had normally advanced in size, the flexion remaining, though not so marked as before. She was then sent to her home for nature to cure her, unless another violent attack of the stomach trouble returned. A few days ago she was doing well, and now, in all probability, will go to full term (February 1st-15th). The treatment consisted in the administration of the usual homœopathic remedies, but without apparent results, doubtless owing to the fact that the cause of the difficulty was meanwhile operative.

On Wednesday, April 13, 1898, I received a message from Dr. Emily F. Swett, of Medina, to meet her in Knowlesville for a consultation regarding a patient who had been confined to her bed for six weeks from great weakness, and with uncontrollable nausea and vomiting in pregnancy.

The patient was about 35 years of age, had been married several years, and had borne two children without important complications. According to the best estimate she was now four and one-half months advanced in gestation. From conception to the present time she had suffered incessant nausea and vomiting, had gradually lost flesh, and was rapidly approaching a condition of pernicious anæmia. Her knees and elbows were congested and swollen, her mouth was sore and salivated, she was hardly able to raise her head from the pillow, her temperature was 100°, and her pulse 140. I advised her immediate removal on a stretcher to our hospital, for the purpose of inducing miscarriage. She came the next day without accident, and on the following morning she was removed to the operating room, where an attempt was made to forcibly dilate the cervix with Wiley's and other dilators. On account of the severe hæmorrhage, dilatation was abandoned, and a curette, this instrument being free from danger to the mother, was introduced into the uterine cavity to puncture the membranes and disturb the state of gestation. Then a strip of iodoform gauze was inserted within the cervix, and the patient returned to her bed.

On the following morning she complained of normal labor-pains, which progressively increased throughout the day. In the evening she was removed to the operating table, when the cervix was found hard and unyielding, but dilatation, to the best of my memory, was about the size of a half-dollar. A stream of sterile water, temperature 110°, was directed against the cervix for half an hour, when the patient was replaced in bed in one of the recovery rooms for better rest, and to give natural methods an opportunity to complete the labor. After an hour or more she was returned to the table, and dilatation was now sufficient to allow the introduction of several fingers within the cervix, thus enabling me to grasp the head of the fœtus, which was quickly delivered with placenta and membranes intact. To my surprise, while examining my patient, another fœtus presented feet first, as usually obtains in duplicate pregnancies at full term. This was likewise quickly removed, with its separate placenta and membranes in normal condition. The patient was immediately removed to her bed in the recovery room, and allowed to rest for several hours.

This ends the surgical part of this interesting case, for there seems to have been but little shock, her temperature being 100° and her pulse 130, following the operation. On the third day the temperature was 102° and the pulse 140, doubtless induced by this particular time after confinement. The eighth day the temperature was 99° and the pulse '100. The pulse gradually came down to normal, and she was discharged from the hospital the twenty-eighth day in her usual, yet naturally enfeebled, condition. It must be remarked, however, in passing, that during these four weeks she was very melancholy at times, and suffered much pain from indigestion in the stomach and bowels. The diet was carefully selected, consisting of hot milk, malted milk, egg and milk, hot eggnog, beef broth, white of egg with lemon juice, whisky and milk, sherry flip, cocoa, cracked ice, iced champagne, etc., while the remedies administered were aco., ars., bell., china, colo., ign., nux vom. and sulph. And I take this opportunity to affirm that their action hitherto in my experience was never more prompt and satisfactory, and emphatically illustrated the fact that homœopathy, within its sphere, is the safest, surest and most beneficent system of therapeutics ever practiced or proclaimed.

"J. Fabre notes a case of uncontrollable vomiting in a primipara, 18 years of age, who had previously suffered from anæmia and hysteria. The vomiting began at the fifth month of pregnancy and had continued up to eight and one-half months, with increasing weakness. The fœtal heart was not to be heard, yet the vomiting continued, and medicinal means were of no avail. It was therefore decided to induce premature labor, and Krause's method (introduction of a bougie into the uterus) was employed. On the day before this was done the patient was so weak as to require injections of caffèin and ether, and of 200 gm. of artificial serum into the subcutaneous tissue of the abdomen. Twelve hours after the introduction of the bougie into the uterus a dead female fœtus was delivered by forceps. The vomiting still continued, and the patient died twelve hours later. The only lesions found at the necropsy were those of recent gastritis. (The case is interesting, for the death of the fœtus was not followed by a cessation of the vomiting, a circumstance probably due to the fact that here pregnancy was not the sole factor, but had superadded to it the pathologic state of the stomach.)"

“Kehrer reports the case of a hysteric woman, aged 21, who not long after marriage aborted at four months. During this brief pregnancy she had been greatly troubled with nausea and vomiting, which were not relieved by narcotics. She soon became pregnant again, and at once began to suffer severely from nausea. After various remedies had been tried, including the application of a solution of silver nitrate, an effort was made to end the nausea by partially dilating the cervix with the finger. While very brief improvement followed, no permanent cure resulted. The patient's condition became so serious through weakness, loss of flesh and failing strength, that it was determined to empty the uterus. With a view to bringing on labor-pains, Kehrer tamponed the os and cervix with strips of sterile gauze soaked in glycerin. The nausea immediately stopped, and a period of several days, in which the patient was free entirely, followed the use of the tampon. After a short time the symptoms reappeared, when the tampon was again employed with a similarly successful result. Kehrer was able by this method to carry the patient along in pregnancy until the thirty-third week, when labor was induced, and she was delivered of a living child. The infant was at first partially asphyxiated, but speedily revived, and became normal in strength and weight.”

More cases might be related, but these will suffice to illustrate the variety of conditions we meet (of course irrespective of so-called physiological nausea in gestation, which does not now concern us), and make clear to our minds how dangerous the condition when uncontrollable nausea and vomiting complicate the pregnant state. But, Mr. President, the principal object of this paper will not have been attained unless we analyze and inquire concerning some of the many causes underlying this difficult and important subject.

Doubtless, in the first and second cases reported, the uterine flexion, in the absence of other evidence, was the principal pathologic lesion, operating by reflex irritation through the sympathetic nervous system, which caused the irritability of the stomach. This is the usual explanation in such conditions, and need detain us but to remark that Graily Hewitt, in the *Transactions of the Obstetrical Society*, of London, 1872, p. 103, attached great significance to flexions and versions of the

uterus as causes of the hyperemesis of pregnancy. In the first case it may be remarked, in passing, that while the thorough examination and the sound were only employed for diagnosis, they served an additional purpose in that miscarriage quickly followed their use, completely emptying the uterus of a dead embryo which had been there too long already, as indicated by the subsequent rise of temperature and the necessity for curettement and irrigation. In the second case we have much to learn; a false modesty prevented the discovery of an important uterine disease that not only caused her years of unhappiness and pain, but well-nigh sacrificed the life of her offspring. Then, too, we may know that while these cases are prone to abort during the first three months of gestation, many of them by careful treatment may be carried along to the fourth month, when, if the fœtus shall be alive, the uterus is quite apt to straighten out from natural causes, and thus allow these patients to go on to full term.

In the third case we have a different state of affairs, but none the less interesting; we are not now confronted with a flexion, but with a duplicate pregnancy and separate placental attachments, which, so far as our information goes, were the only differences between this and her previous pregnancies, unless, perchance, the nervous system was deranged, or the stomach itself affected, and thus more susceptible this time to sympathetic irritation. The question naturally arises, Could this extensive attachment of placental tissue, with the stomach and digestive organs in a healthy condition, cause the nausea and vomiting in this case? I think not, for the history of multiple pregnancies, with a few exceptions, does not warrant this conclusion.

Regarding the cases quoted, we are somewhat handicapped without personal knowledge; yet, as presented, they are alike interesting and instructive. In the first one, you will remember, the artificial interruption of labor was not followed by cessation of the stomach symptoms, and the patient died twenty-four hours after the operation. We are told that the vomiting began at the fifth month, continued three and one-half months; that the necropsy showed evidences of recent gastritis, and that "medicinal means were of no avail." It is manifestly unfair to conclude that a different system of medication would have

been followed by different results. In the last case reported the medical treatment is more explicitly stated, and is open to serious objection and criticism from our standpoint; while the mechanical means employed—that of partially dilating the cervix with the finger, and the intended, though futile, interruption of pregnancy by the tamponing of the “os with strips of sterile gauze soaked in glycerin”—seems to have had a happy result by carrying the patient along in pregnancy until the viability of the fœtus was positively assured. In this connection it is pertinent to inquire how it happens that, while this treatment to the cervix in the pregnant state will relieve reflex irritation, even a small amount of cicatricial tissue in the cervix, caused by imperfect union from laceration in childbirth, is frequently followed by nervous reflexes of the most troublesome character? A discussion of the mechanism of the reflex vomiting of pregnancy from one familiar with such phenomena would be intensely interesting, but beyond the scope and purpose of this paper.

GUARD THE HEART IN PNEUMONIA!

BY EDWARD R. SNADER, M.D., PHILADELPHIA, PA.

(Read before the Homœopathic Medical Society, County of Philadelphia, November 9, 1898.)

THE cause of death in croupous pneumonia is, in the large majority of cases, due to heart failure. It is true that high temperature, that febrile toxæmia, that auto-intoxication, that respiratory failure, that toxic myocarditis, that endocarditis, pericarditis, that pleuritis, that pre-existing maladies or complications of varied character, may indirectly determine the fatal issue, the heart failure then existing being only an important detail of the death picture; but these cases are simply the minority that make the background of the big majority of deaths from specific cardiac bankruptcy the more evident and prominent.

If the proposition I have just made be admitted, it follows that to guard the heart against the ills that may happen it from numberless sources during the progress of a pneumonia,

and to sustain the fort of life, the heart, in its fight against the combined forces deployed *en masse* during the crisis, or the sapping and mining of a slower ending of the malady by lysis, is a duty of such great importance as to almost overshadow other considerations.

While you know and I know that there are many other states and conditions that require intelligent and skilful control during the progress of a pneumonia beside the heart, we cannot but realize that, in many instances at least, the strength of the heart determines the favorable or fatal issue. I believe that no symptom should be neglected in the treatment of lung fever, but I also believe that the cause of the greatest number of deaths should be fully realized, fully comprehended, fully armed for.

It is more than a duty, it is imperative, that at the very outset of a croupous pneumonia the strength of the heart be measured and its status as to its capability of standing a state of siege of ten days or more be estimated. We must ask ourselves whether the heart has been previously damaged by disease; whether there is an adhesive pericarditis; whether there is a valvular disease; whether myocarditis, fatty degeneration, dilatation, hypertrophy, be present; whether the patient has a Bright's, a diabetic, a gouty, an anæmic, an alcoholic, an athlete's heart. In other words, is the patient handicapped at the outset of the race for his life by a heart *intrinsically* incompetent before he has barely felt the baleful effects of the new malady? Most of those with intrinsically weak hearts die before the crisis—the greatest danger period of pneumonia—before, indeed, the major portion of the burden that pneumonia lays upon the heart has had time to produce more than its initial effects.

You want this preliminary knowledge of the cardiac status, not only for prognosis, but in order to begin at once the conservation of every atom of the heart's strength and save the patient if possible. With this advance knowledge you will not be surprised at the early surrender of the heart; you will be in position to anticipate all the disease possibilities, and, in some cases at least, be rewarded for your keen foresight by the saving of a life that would otherwise surely be lost. Now, even if the heart be organically diseased, it does not always

follow that death will ensue. Many cases of valvular heart disease have been carried safely through pneumonia. A few slight dilatations in short-lived pneumonias have recovered. Myocarditic, fattily degenerated, dilated, Bright's and alcoholic hearts are most to be feared. The dictum I would enunciate, then, is, the heart must be *measured as to its muscular power*, whether it is organically diseased or not. The practical fact, in the sick-room, is that some hearts that are not discoverably diseased organically are absolutely weaker than some others in whom the evident signs of organic change are present. Independently then of organic disease, or taking organic disease into the survey, the heart is measured as to its actual power as a pump and as a vital organ. When you have summed up your case, you are ready to act or to withhold action.

Now let me give you another practical fact. Every heart does not require specific treatment. Some hearts require sedation; some require toning; some require driving; some require whipping, lashing, goading; some require to give the last ounce of strength in them to tide your patient over. Every heart, however, must be watched with the eye of a hawk and the acutest hearing from start to finish. That watching, however, tells you when to treat, when not to treat, and, measurably, too, how to treat. Not only the heart itself, but the arteries, the veins, the capillaries, the nervous supply, the virtual adnexas of the heart, must be considered as part of the cardiac apparatus.

Let us briefly go over the factors that make the heart bear the brunt of the attack in pneumonia. The antecedent history of the patient, to a certain extent, measures the intrinsic, essential heart condition at the onset; but what about the extra burdens borne as the direct result of the pneumonia? The preliminary chill, the sustained high temperature (with its essential tendency to produce parenchymatous tissue-changes in the heart-walls as well as in other structures), the febrile toxæmia, the auto-intoxication, the ptomaine poisoning, are all important factors in producing cardiac weakness; but they are present, in nearly equal degree, in all highly febrile diseases, and in diseases, too, in which heart failure *per se* is not so prominent an incident as in lobar pneumonitis. The added

burden in pneumonia that determines the more frequent death from real cardiac incompetence is (it is reasonable to suppose) largely a mechanical one. I mean that the great congestion of the lungs and the enormous consolidation by reason of vital mechanics largely determine the special predilection to heart failure found in pneumonia.

In your mind's eye, for one second, gaze at a lung lobe or lobes gorged, solidified, rendered nearly impervious to the entrance of air over a large area; see the crushed arteries, the cramped capillaries, the pressed veins, the lamed lymphatics, crowded to the walls of the air-cells by the pressure of the weight of one, two, three, four pounds of pneumonic exudate; see the arterial flow going to the bronchi dammed back to the left auricle; see the gorged arteries, veins, capillaries that lead to the seat of disease; they cannot empty themselves fully. The heart, the poor right heart, keeps pumping, pumping, pumping against the solid lobe, and yet it cannot empty its vessels. If this pumping keeps up long enough, and the obstacle does not yield, the right ventricle must give way. Here you have an adequate reason why the heart should specifically fail in pneumonia. The back pressure in the lung is thrown upon the heart too overwhelmingly, too acutely, for the cardiac muscle to attempt compensation; it must simply fight for an existence. Think, too, of the now unequal work of the two ventricles, and how it would of necessity disturb the equipoise of nervous balance; how the sympathetic and pneumogastric and cardiac nerves and the auto-cardiac systems must be thrown awry by this limping of the right ventricle and the unbalancing of the functions of respiration, where a third of the air-vesicles are on strike and will not oxygenate blood, crushed, flattened against each other by the army of red-coated corpuscles that have stormed and breached the walls of the air-cells, and fibrin, and epithelial cells, debris and a few renegade leucocytes. Think of the left ventricle pumping away against high-tensioned arteries and capillary semi-paresis, unbalanced, too, because not working in harmony with its yoke-mate, the right ventricle. There is reason enough, I think, for specific heart failure.

I want to say right here that most hearts have sufficient reserve strength to weather a pneumonic storm. It is my firm

conviction that the heart is, early in the disease, given too much therapeutic attention. I say this because I do not want anyone to think that, because heart failure is likely to occur in lobar pneumonia, he must begin pounding away at that already much abused organ simply because cardiac weakness belongs to the history of acute lobar consolidation. Anticipatory therapeutics are all right, and anticipatory therapeutics save many a life; but anticipation does not mean that you shall specifically treat an organ doing fairly well because it *may* fail to do so two weeks hence. In other words, to treat a possible heart failure in the future by attacking the heart in the present is not only courting that failure, but is positively inducing it. A heart in acute disease cannot stand drugging day in and day out. That organ has its limited share of physiological irritability, and that irritability, that inherent power of reserve, can all be exhausted before the real gage of battle, the crisis, has been thrown into the therapeutic arena.

The real attitude of the doctor, in most cases not inherently, intrinsically, organically weak at the start, is one of masterly inactivity so far as mere drugs are concerned, and one of vigorous insistence on all those by-measures that shall *conserve* the heart's strength against the major fight yet to come. By such a course, indeed, one often succeeds in avoiding that which they most feared—uncontrollable heart failure. These by-measures that conserve the heart's strength are the reduction of a too high temperature by spongings, or even cold packs, if necessary; by flushing the kidneys; by keeping the bowels open; by assisting skin elimination; by assuaging dangerous cough; by liquefying tough pneumonic exudate; by promoting absorption of the inflammatory mass; by promoting sleep; by controlling restlessness; by mitigating pain; by proper feeding. Now most, if not all, of these means for the conservation of the heart's strength can be secured without the administration of drugs, and by means, therefore, that leave the field of medicine clearer for you, if you must act specifically on the heart.

In point of fact these so-called conservators of the heart's strength are after all the principal, the most reliable, the most frequently successful methods of preventing cardiac failure. In other words, we do infinitely better by preventing heart failure than by treating it after it has appeared. The number of vic-

tories that drugs score in high degrees of heart failure in acute pneumonia are lamentably small, and this, too, no matter whether the drugs are given homœopathically, allopathically or empirically. The conservation of cardiac energy, therefore, is only another exemplification of the old saw "An ounce of prevention is worth a pound of cure," and is the kind of anticipatory therapeutics which I most heartily endorse.

Unquestionably, too, the drugs given for the inflammatory process, in the first stage, as aconite, veratrum viride, belladonna, gelsemium, if not pushed too hard, assist in preventing future heart failure by lowering arterial tension and quieting the over-excited cardiac action. Aconite and veratrum viride, particularly, may also be needed later, in our efforts to guard the heart, in order to secure sedation.

How shall we keep ourselves informed of the condition of the cardiac apparatus? By repeated examinations, you say. Yes; but how shall you examine? Shall you interrogate the radial pulse? Oh, yes; for the radial pulse will tell you the amount of blood-pressure and arterial tension, the condition of the capillaries as to practical stenosis, and, greatly, the status of the systemic circulation; it will give you, too, an approximate, but only an approximate, idea of the condition of the heart. But an examination of the radial pulse will not give you an idea of the real state of the pneumonic heart.

Where, pray, do you feel the pulse of your right ventricle, the one that bears the brunt of battle and ultimately drags the left ventricle into its own dire distress? Yes, the radial pulse is like a peripheral telegraph wire. Messages are transmitted over the artery from the one room in the præcordial central station, but the message is not complete, because the communication of the left room with the right room is irregular and interrupted—the nerve-wires are awry, and the keyboard of chordæ tendineæ and papillary muscles is working on its own account, jangling, out of tune, emitting false clicks and dots and dashes, and some of this conglomerate message goes down the left ventricle arterial wire and some does not. Now, over the tricuspid area is a real telegraph station, wherein general messages are received from the liver district, from the cerebral district and from the lung district, where you can learn the condition of the right ventricle. That right ventricle must be interrogated

directly and specifically if you would know the actual working condition of the right heart. Question both ventricles, but remember that the first signs of heart failure in acute pneumonia are generally found in the right ventricle—always, you might say, if the heart failure is not due to intrinsic cardiac causes, and is due to the pneumonia alone. Over the tricuspid area you hear the *lup, dup, lup, dup*; and it is by the modifications that take place in the first and second sounds, as well as by the rhythm and intermissions and irregularities, that we mainly decide upon the condition of the right ventricle.

The pulmonary second sound is accentuated, and for two reasons: first, the back pressure from the vessels of the diseased lung lobe, and second, the increased work of the right heart. You are told in the text-books that when this accentuation diminishes your heart is failing, and when the sound is nearly lost the case is most grave. I should say it was, and overwhelmingly, too; it has failed to such an extent that only an act of special Providence will save the patient. This classical diminution or obliteration of the pulmonic second sound is not practically a reliable guide as to the existence of remediable degrees of heart failure. There is generally present back pressure enough from the lungs to keep the pulmonic second sound decidedly accentuated up to the last gasp. The more reliable guides are the amount of muscle element in the first sound of the heart, the shortening of the long pause, and the heightening of pitch of the first sound. The more valvular the first sound of the heart, the greater the danger. Now, simply because you find the heart rating along at 100, 120, 130, do not think that imminent heart failure is of necessity upon you. Don't begin the use of your heavy artillery now. Don't, don't, don't fire until you see the whites of the enemy's eyes. Unless the crisis is on, send out a column or two of skirmishers. They may be able to help you to reserve your major forces. Save your twelve-inch guns until you are actually in the crisis. A heart that is beating at the rate of 120 may require to be quieted, not whipped. When, with such a rate, or higher, the heart appears to be acting excitedly, violently, a sedative, not a tonic, is needed. The heart then is like a young colt running away, carrying no burden but its skin. Sedation with the indicated drug will calm the heart and make it do some of its

work at least, and truly conserve the cardiac strength for the real battle. Do not drive such a heart; you are only whipping the runaway colt. Control, regulate, conserve the heart's power.

When the crisis is near and the first sound weakens, fire a heavy gun. If the first sound does not gain more of the muscular element and the crisis is at hand, and the heart is irregular and intermittent, bring all your therapeutic batteries to bear, for the heart's Waterloo is at hand.

What about the weapons with which to fight heart failure? Well, they depend altogether upon the conditions that specifically caused the heart failure, and upon the by-results you must produce in the rest of the cardiac apparatus. If high fever is the greatest factor, cold packs and bold alcoholic stimulation; if from auto-toxæmia, kidney and skin elimination; if from capillary stasis, glonoine; if from cyanosis due to a great area of lung tissue that cannot aërate the blood, oxygen; if from too rapid liquefaction and collateral œdema, aromatic spirits of ammonia; if from failure in the nervous supply, strychnia straight; if from failure of the sympathetic system's nervous supply, strychnia sulph.; if from both cerebro-spinal and sympathetic failure, and the arterial tension is too high, strychnia nitrate; if the capillaries are relaxed and the arteries toneless, digitalis; if the skin vessels are nearly normal and the pulse tension neither too high nor too low, strophanthus, etc., etc.; if your right ventricle is enormously engorged and there is no response to drugging and you feel that an hour's delay may save a life, bloodletting, to give the heart muscle a little time to take up its slack; if most of the blood seems in the thoracic organs, or the system seems overwhelmed by toxins, saline injections, etc., etc.

It is not the purpose of this paper to discuss all the measures that may be useful in cardiac asthenia, nor to consider such in elaborate detail, but simply to indicate, to suggest, the factors that may, in a given case, determine the choice of a medicine or measure that will help tide over a case to safe convalescence. I want to say most emphatically that in strict individualization of a case lies the only hope of success. The heart that recovers under haphazard therapeutics would have recovered without them. The recovery is due to inherent heart power.

In other words, drugs that do not specifically help the heart actually hinder it.

If you have tided your patient through a grave crisis do not stop your drugs at once; diminish the dose and return to routine treatment gradually. You have mortally wounded your enemy and he has fallen, but he may fire from the ground as a last desperate chance. It is true that the heart soon returns to a normal rate after the crisis, even although the lung is still consolidated. But the heart is not now lashed by the whip of fever, and the consolidation in the lobe is softer and the blood can be the better pushed through the vessels, while the lymphatic scavengers are busy at work. But the heart has had a big burden taken off its shoulders, and in that new relief can better take up even its yet great burden. But give you the heart yet a little aid; don't withdraw your support too soon.

In conclusion, let me say: Never do one single thing therapeutically without a distinct, clear-cut idea of what you purpose doing. Adapt specific means to specific ends. Individualization, discrimination, clear-eyed comprehension of the difficulty and the means of overcoming it are the keynotes of success. Don't commence drugging too soon. Don't quit too soon. Employ a drug rifle if you can; if that don't work, use shrapnel or a battery of twelve-inch drug guns; but be sure that you know exactly what sort of help and what sort of damage your firing is going to do. Finally, remember that you are treating a *patient* suffering with pneumonia, and not a pneumonia with a patient hanging thereto as a most inconvenient and inconsiderate adnexa. You want to save the patient, not the pneumonia.

THUJA IN PSORIASIS VULGARIS.—Dr. H. observed a case of universal psoriasis vulgaris in a young girl of 12 years, with associated general weakness and depression, where, after administration of various drugs, thuja occ. 3x was given, twice a day, for four weeks, with the result that the whole eruption had in that time nearly entirely vanished, except around the knees and on the extensor sides of the arms. A continuance of the remedy soon removed all traces of the eruption. The condition was hereditary from the father's side. He also employed a vegetable diet of milk and eggs, together with an air bath every second evening, either in the room or the open air, in summer.—*Leipziger Populäre Zeitschrift fuer Homœopathie*, Nos. 19 and 20, 1898.

THE WHOLE IS GREATER THAN A PART. A STORY.

BY CHARLES S. MACK, M.D., LA PORTE, INDIANA.

"WELL," said Fetters, when we were all seated, "our club has asked you in to tell us something about homœopathy. We want you to feel at home with us, and to understand that we have no prejudice against homœopathy—that we really want to learn about it, and that our feelings toward you are entirely friendly."

The club was *The Æsculapian*, composed of twenty or more seniors in an old-school medical college. Fetters was their president, and in his room they were met. He addressed Freeman, a senior student in a homœopathic college, whom the Æsculapians had invited to meet with them on this occasion and talk with them upon the subject of homœopathy. A delightful air of sociability and good-fellowship prevailed. Cigars and pipes lent fragrance to the atmosphere.

"Certainly I feel at home here," said Freeman. "Homœopathy or no homœopathy, tobacco makes brothers of us all. Now, how shall we begin? Do you want to ask me questions, or shall I start in and go as I please?"

"Go as you please, and let us ask questions as they occur to us," suggested one of the Æsculapians. "That's the best way," said another, "if it's agreeable to Freeman." The way was agreeable to Freeman, and so he began.

Freeman—Well, in the first place it is important to understand that the cure attempted in any practice of homœopathy is essentially different from that attempted in any given rational practice or in any intelligent practice of empiricism. Unless one sees just what characterizes the cure of which *similia similibus curantur* is the law, he is liable to fall into the very serious error of supposing that one cannot consistently accept and cultivate homœopathy and at the same time accept and cultivate rational medicine and empiricism. Many have fallen into this error; the whole body of the regular profession seems to be in it at this minute, as do the few homœopaths who urge that nothing is good in medicine outside of homœopathy.

An Æsculapian—I thought you homœopathists claimed, in theory if not in practice, that homœopathy is all of medicine. Do you mean to say that you advocate rational medicine and empiricism as well as homœopathy?

Freeman—That's exactly what I mean to say.

Second Æsculapian—I guess, Freeman, that you have a chore on your hands if you propose maintaining such a position as that. I can understand how a man can be misled into a belief in homœopathy, but for the life of me I can't see how he can believe in homœopathy and at the same time believe in rational medicine and empiricism. You believe, don't you, that *similia similibus curantur* is a law of nature?

Freeman—Yes.

Second Æsculapian—Well, if you believe that's a law, how in the name of common sense can you advocate practices which that "law" does not sanction? It seems to me that if you are going to advocate rational medicine and empiricism you must give up your belief in *similia* as a law. Isn't it so?

Freeman—Not at all. *Similia* is the law of a cure, but not the only cure. I began just now by urging the importance of understanding that the cure of which *similia* is the law differs from any that can be attempted in rational medicine or in an intelligent practice of empiricism. Do remember this, for you will never understand the subject of homœopathy until you see what characterizes the cure of which *similia* is the law—what differences that cure from any that can be attempted in rational practice or in an intelligent practice of empiricism.

Third Æsculapian—To my way of looking at things, a cure is a cure. You talk as if there were different kinds of cure, and as if you wanted them classified, as are the genera, species and varieties of animals, plants and minerals.

Freeman—That is precisely what I do want, and until it is done homœopathy will not be understood. The cure of which *similia* is the law is as different from any that can be attempted in rational medicine as one genus of animals or plants is different from another.

Third Æsculapian—What characterizes the cure of which *similia* is the law? What differences it from the cures attempted in rational medicine? Can you tell us?

Freeman—I can. The cure of which *similia* is the law is an

immediate transformation from abnormal to normal (or approximately normal) of vital processes, and, in consequence, their effects. This cure cannot be attempted in rational practice.

Third Æsculapian—Why can't it?

Freeman—Because in any given rational practice the immediate object aimed at is a change in conditions which are *in themselves* knowable, as vital processes are not—they are known only *in their effects*.

Fetters—This is getting too deep for me. You may be right, Freeman, but if medical students are to understand all this they must be trained in logic and philosophy as well as in medicine. I can't follow you.

Freeman—Well, it wouldn't be a bad thing if medical students were trained in logic and philosophy. Certain it is that without philosophy and logic no step forward in medicine can be made, excepting by chance. But I don't see that there is anything very deep or abstruse in what I have been saying. What don't you understand?

Fetters—I don't understand what you mean by vital processes knowable not in themselves but only in their effects.

Freeman—What is life? We know not, but we know its effects. What keeps the mind active, the lungs in motion, the heart beating? What keeps the liver, the kidney, every gland, yes, each cell in the body, in the performance of its function? It is life. But life we know only *in its effects*; we observe the effects of vital processes, but we do not know the processes *in themselves*.

Fourth Æsculapian—Don't food and drink and air become converted into life?

Freeman—Never. Life comes down from above, and is manifested through a living body when proper conditions are maintained. Among those conditions are supplies of food, drink and air; but these things are not transmuted into life. When life has gone out of the body, when the body is dead, food, drink and air will not restore life. They are conditions to the continuance of life in the body, but life is not made of them; the continuance of vital processes is dependent upon them; but vital processes are operated from above and within the body, while food, drink and air are supplied from below and without. You see what I mean, don't you?

Fifth Æsculapian—I see what you mean, and to me it seems an argument in favor of what I half believe, viz., that drugs are of no use anyway, and that really all a physician can do is to secure hygienic conditions.

Sixth Æsculapian—Oh, come off! That's fatalism. Of course drugs are useful. I understand Freeman's definition of the cure of which he believes *similia* to be the law, and I see that it cannot be attempted in rational medicine, because, as he says, in rational practice our immediate object is to effect a change in conditions which are *in themselves* knowable, as vital processes are not. To me Freeman's definition is perfectly clear, but my question is whether any such cure really exists. Supposing I should deny its existence, what would you say, Freeman?

Freeman—I should say you were perfectly at liberty to deny it. Whether there really is such a cure I regard as a question of opinion. For my own purposes I am perfectly satisfied that there is, but the point is one upon which each man should be left in entire freedom to form his own opinion. When the medical profession, as a whole, leaves each man in freedom to hold whichever opinion he will upon this point, to either believe in or disbelieve in this cure and in *similia* as the law of it, they will have made a great step in advance. At present nine tenths of the profession ostracize any man who avows belief in this cure and in *similia* as the law of it.

Seventh Æsculapian—The profession doesn't ostracize homœopathists; it simply objects to their assuming a name which differences them from the rest of the profession. Freeman himself tells us that he believes in rational medicine and empiricism just as much as he does in homœopathy. Isn't that so, Freeman?

Freeman—Yes.

Seventh Æsculapian—Why, then, do you identify yourself by name with homœopathy rather than with rational medicine or with empiricism? Why do you call yourself a homœopathist?

Freeman—Nine tenths of the medical profession regard rational practice as the *ne plus ultra* in therapeutics. They either deny, or are indifferent to, that cure which transcends the possibilities of rational practice, and are violently opposed to recognition of *similia* as the law of it. By the name *homœopathist*

I identify myself with *similia*, that I may be known as an advocate of this transcendent cure, that I may be distinguished from those who regard rational practice as the *ne plus ultra* in therapeutics.

Eighth Æsculapian—Stop chewing that rag. There is no manner of doubt that the regular profession has made a mistake in ostracizing homœopathists; the regular profession knows this perfectly well, and has been eating crow for years. You can't hurry them, but it is inevitable that they will sooner or later throw down the fences they have erected to exclude homœopathists from association with them. Nothing could be clearer or fairer than Freeman's putting of the case. Classification of kinds of cure makes it clear that the cure of which *similia* purports to be the law differs from any that can be attempted in rational medicine, and transcends the possibilities of rational practice. I very much doubt if I shall ever identify myself with societies of the regular profession until they so modify their requirements for admission that a man may enter them without committing himself against homœopathy. The regular profession may say what it pleases, but no man can join its societies, as at present constituted, and remain free to form an unprejudiced opinion on the subject of homœopathy. I'll be hanged if I'll have anything to do with them until they change their tactics. There is no sense in their requiring a man to slap homœopathy in the face as a condition to joining them, and still saying that they want him to remain perfectly free to believe in and practice homœopathy, if it commends itself to him—that they simply don't want him to take the name *homœopathist*. It's absurd. I have no patience with it. Were free-traders or abolitionists, or any other adherents to a cause, ever asked to advocate their views but to abstain from identifying themselves by name with those views? It's ridiculous. Any one who believes in homœopathy is a homœopathist, and had better say so. We members of this club are seniors, and will be expected within two months to join societies of the regular profession. We can't do it without taking a stand against homœopathy. Do we know enough to take that stand intelligently? I certainly don't.

Fetters—To change the subject. I understand now what you mean by vital processes, and I see that the cure of which *similia*

purports to be the law transcends the possibilities of rational medicine, but how is it with empiricism? Can't I attempt that cure in an empirical practice?

Freeman—Not intelligently, you can't. You might in an empirical practice hit upon that cure, but in no given case could you have any reasonable expectation of effecting it. The reason of this is that empiricism, in looking at past practices, concerns itself only with known terminations, not with the immediate action of a drug upon vital processes in themselves unknowable.

Ninth Æsculapian—I'm right onto that.

Tenth Æsculapian—I, too. It's as straight as a string. You make clear, Freeman, what I never heard of before, that one cannot at all attempt in rational practice, or intelligently attempt in empirical practice, the cure of which *similia* purports to be the law. As you have been talking, the question has come to my mind whether definition of the cure of which *similia* purports to be the law isn't the key to the solution of the whole controversy over homœopathy.

Freeman—I have no doubt it is just that. Any discussion of homœopathy is at loose ends, and must be so, unless it is preceded by accurate definition of the cure of which *similia* purports to be the law. For lack of such definition Brunton's discussion of the subject is at loose ends, and so is H. C. Wood's, and so is Stillé's, and so is Headland's.* In my mind there is no manner of doubt that this controversy will have no end until the disputants agree as to just what cure *similia similibus curantur* purports to be the law of.† When they agree upon that point they will understand one another as to what they are talking about. Until there is agreement upon that point all discussion will be at loose ends. Define the cure of which *similia* purports to be the law, and then hold disputants to the point.

Tenth Æsculapian—That's right. To hold disputants to the

* See in the *American Medical Monthly* for October, 1897, the article, "Brunton, H. C. Wood and Others on Homœopathy;" in *THE HAHNEMANNIAN MONTHLY* for February, 1898, the article, "F. W. Headland, M.D., on Homœopathy;" and in the same journal for April, 1898, the article, "Stillé and Homœopathy."

† See in the *New York Medical Journal* for August 13, 1898, the letter headed, "Of What, if of Any, Cure is *Similia Similibus Curantur* the Law?" and in *The Philadelphia Medical Journal* for September 10, 1898, the letter headed, "An Attempt at a Needed Definition."

point would save a lot of rambling, desultory talk on the subject of homœopathy.

Fetters—You certainly have answered my question most satisfactorily. I clearly see not only that the cure of which *similia* purports to be the law transcends the possibilities of rational practice, but that one cannot in empirical practice attempt that cure with any reasonable expectation of success. I see the importance of accurately defining the cure of which *similia* is the law. It is evident that without such definition one cannot be up-to-date upon homœopathy as a part of medicine. Can I find anywhere in print the views you have been presenting? I should like at my leisure to further consider them.

Freeman—Yes; they are elaborated in a little book entitled *Principles of Medicine*.*

Eleventh Æsculapian—I have read that little book, and it puts the whole subject of homœopathy in a light that was new to me. It shows that, as the cure of which *similia* purports to be the law transcends the possibilities of rational medicine, those who believe in that cure and in *similia* as the law of it have every reason in the world to band themselves together as homœopaths. It makes perfectly clear that, as that cure differs from any that one can attempt in rational practice or intelligently attempt in a practice of empiricism, one may with entire consistency accept and cultivate all three—homœopathy, rational medicine and empiricism. The fact is that the regular profession, because it holds itself aloof from homœopathy, is cultivating only a part of the field of medicine, while homœopaths are cultivating the whole field. I quite agree with Shackleless (*Eighth Æsculapian*). I'll have nothing to do with any society over whose door is the sign, *No Homœopaths Need Apply*, until it takes down that sign and puts in its place this other, *Homœopaths Wanted*.

Twelfth Æsculapian—Do homœopaths accept serum therapy? Do they use anodynes, palliatives and external applications?

Shackleless—A homœopathist accepts whatever commends itself to him; he uses what he pleases. You must have been asleep. Wake up; it's time to go home.

At a late hour the Æsculapians adjourned *sine die*.

* By Charles S. Mack, M.D. Published by the Chicago Medical Book Company, 35 and 37 Randolph Street, Chicago.

THE SURGICAL TREATMENT OF TUBERCULOUS LYMPHADENITIS.

BY WALTER STRONG, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society, State of Pennsylvania, Pittsburgh, Sept., 1898.)

ALTHOUGH tuberculosis of the superficial lymphatic glands is a very common condition, it is a most important subject for our consideration—a subject presenting many interesting and intricate problems which merit the attention of both physician and surgeon; moreover, it is a subject having considerable bearing upon the ætiology of general tuberculosis.

Unfortunately, the limited time at our disposal will not permit of a thorough consideration of all the phases of this subject. Consequently I shall be compelled to limit myself to the surgical aspect of the disease, together with the operative treatment, with which I have had considerable experience.

Tuberculosis did not until quite recently claim the attention of the surgeon, for although the inoculability of tuberculosis was accidentally discovered by Laennec in 1826, and the same demonstrated experimentally by Villemin in 1865, it was not looked upon as a surgical disease until the discovery of the specific bacillus by Koch in 1882, since which time it has received much attention from surgeons, until to-day we find that it is more of a surgical than a medical disease.

By far the most common variety of tuberculosis met with in surgical practice is tuberculosis of the superficial lymphatics, occurring, as it does, at all ages, from infancy until late adult life. It occurs both independently and in combination with all other forms of tuberculosis, forming a most important disease in surgical work.

The importance of a thorough knowledge of tuberculosis of the lymphatics cannot be overestimated—important to both physician and surgeon. It not only represents a typical variety of tuberculosis with a typical course, but explains in a very large degree the cause of tuberculosis in other tissues and organs, and the development of general tuberculosis.

Osler is responsible for the statement that three-fourths of all

cases of acute tuberculosis can be traced to unhealed tuberculous adenitis. Warren, in his excellent work on surgical pathology, tells us that many fatal cases of tuberculosis have their origin in "scrofulous" cervical glands, and, as a picture of such an occurrence, relates a case which had scrofulous glands in childhood, later in life had white swelling of the knee, and eventually died of pulmonary tuberculosis. Carr, from 120 post-mortem examinations performed at Victoria Hospital, London, concludes that tuberculous diseases in children usually commence in the lymphatic glands; while in the Blegdams Hospital at Copenhagen, out of 384 autopsies of children who died of acute infectious diseases 198 showed undoubted tuberculosis, and in all these cases the glands were affected.

That tuberculosis of the lymphatics is a very important factor in the development of tuberculosis in other portions of the body cannot admit of a doubt, but to what extent or in what proportion of cases it is very difficult at present to determine. The statement recently made by Thompson (New York) upon this point is probably as near the truth as it is possible to arrive at the present time. He said that so long as large, inflamed or suppurating glands are allowed to remain unmolested, there is a risk of their breaking down and serving as foci for a general infection of the system.

Turning our attention for a few moments to the anatomical arrangement of the lymphatics, we find that there are, approximately, seven hundred lymphatic nodes in the body. We also learn that they are very intimately associated with the vascular system, and that their distribution throughout the body is very general, being found in all the vascular tissues of the body. They are also divided into a superficial and a deep set, the superficial being located immediately beneath the integument and accompanying the superficial veins, while the deep set are located in the deeper tissues and in the cavities of the body. But at the present time less than one-fourth of these lymph nodes are objects of surgical interference, and it seems very improbable that it will ever be considered justifiable to attempt removal of any large number of those which are located in the great cavities. But in this study of primary infection it is the superficial lymphatics which interest us most.

Considering this disease from an anatomical standpoint regarding those regions most commonly affected, we discover that those glands which are quite superficial are the ones most frequently involved. We also learn that certain regions are more frequently affected than others. Thus, we find the cervical glands involved in 95 per cent. of the cases (Senn). Volkmann tells us that of the superficial lymphatics the cervical glands are most frequently affected, next the cubital, and less frequently the axillary. In children the glands most frequently found diseased at autopsies are the cervical, the mediastinal, the mesenteric and the retro-peritoneal.

From clinical experience we find that this disease is usually a primary disease, as is evidenced by the fact that we very rarely meet with involvement of the superficial glands in severe cases of tuberculosis of other tissues and organs, while secondary involvement of other tissues and organs is repeatedly observed in severe cases of tuberculous lymphadenitis. This disease occasionally, but rarely, results in the development of a general tuberculous lymphadenitis without the involvement of any other organs. Osler has reported two such cases and Miller another, all of which resulted fatally.

That most cases of tuberculous lymphadenitis are directly due to infection from without has been satisfactorily shown by clinical observation, inoculations, and cultivation experiments. Thus we explain the reason why this disease is more common in certain regions of the body. We find that those portions of the body which are most exposed to external injuries, abrasions and slight inflammatory troubles are the regions most frequently affected by this disease. In the groin we have a large number of superficial lymphatics, yet, owing to the less degree of exposure of the legs to the sources of infection, we find that the disease is comparatively infrequent in this locality. The hand, being in active use, is largely exposed to infection, but it is protected in a measure by the hard horny skin covering it, and is rarely infected.

As we have already observed, in the glands of the neck we have the most frequent seat for this disease. And here we find all those conditions present which favor the development of the disease. Here we find that the face and neck are freely supplied with blood; here we have numerous lymphatic glands,

both deep and superficial. In this region we find the parts freely exposed to outside influences; abrasions and slight injuries to skin and mucous membrane are quite common, while eczema and catarrhal inflammations are not uncommon. In fact, in this region we find all those conditions present which are most favorable for infection and development of this disease, and it is in this region that we can most satisfactorily observe and study the course of the disease.

From experimental research we find that a break in the skin or mucous membrane is not essential for infection. Cornet has demonstrated that in guinea-pigs infection of the glands can be produced by rubbing the tubercle bacilli into a mucous membrane without causing any laceration, and in his later experiments has shown that infection of the cervical glands can be produced by introducing the bacilli into the conjunctival sac, the nasal cavity or the auditory canal.

Where infection occurs through a break in the skin, it is usually due to some trivial injury or abrasion. Volkmann has made the statement that infection never takes place through large operation wounds or at the site of severe injuries, but that localization of the bacilli is likely to take place in parts the seat of very slight contusions, or what may appear at the time as an insignificant injury. He explains this by assuming that active tissue-changes occurring during the process of regeneration after a severe trauma prevented the infection.

Starck has recently shown the causative influence of carious teeth; in 113 cases of tuberculous glands 41 were obviously secondary to caries of the teeth, and in 2 cases tubercle bacilli were found in the teeth-sockets. Dieulafoy expresses the opinion that many of these cases are due to infection through the mouth. Zaudy, in an exhaustive article upon this subject, states that the bacilli enter between the gum and tooth, and that caries acts as a predisposing cause. Nicholl says that in 80 per cent. of these cases the cause will be found in the naso-pharynx, and that many naso-pharyngeal catarrhs are tubercular.

Heredity does not appear to play a very important rôle in the ætiology of glandular tuberculosis, most authorities asserting that such cases are extremely rare. Most, however, maintain that a predisposition exists in many individuals to the

development of tubercular diseases, which may have been inherited; that is, in certain families the tissues of the body offer a more favorable soil for the growth of the bacilli. But Frankel and others will not accept even this possibility.

The germs having once gained admission, the first station of arrest is ordinarily not in the skin, but in a lymph node. Here the bacilli meet with resistance, which is vigorous or feeble according to the condition of the individual, and if the conditions be favorable the bacilli may be encountered, overcome and destroyed; but if the conditions are not so favorable, and the soil proves fertile, infection takes place, and we have a localized tuberculosis developed. Possibly the bacilli may all be arrested in a single lymph node, or they may be carried along with the lymph stream and several glands become infected. But in either case we have several centres of infection developed in each infected gland, which cause a more or less intense inflammatory action and result in the mechanical fixing of those centres of infection, together with a blocking of the lymph spaces, so that temporarily, at least, the disease remains both local and limited. But in a comparatively short period of time we find that these centres of tuberculous infection in each gland undergo caseation, breaking down into a mass, the lymph spaces are again opened up and the bacilli carried along in the lymph current, and other glands are infected. The usual course of infection along the lymphatic channels is in the direction of the lymph current, and in this respect the course of the disease is characteristic—so much so that, as has been pointed out by Gerrish, we can in a large degree anticipate the course which the disease will pursue in the different localities. Finally the bacilli are carried into the circulation, and then we have developed either a general acute tuberculosis or tuberculosis of some one of the organs of the body; but the progress of infection is usually comparatively slow, sometimes covering a period of months, or even years.

The diagnosis of this disease is usually quite easy. Inquiry into the course of any given case, together with a careful examination of the parts affected, will usually suffice; but occasionally a bacteriological examination is necessary to clear up obscure cases. Let me call your attention to the following diseases with which it may be confounded:

Syphilitic infection of the glands of the neck or elsewhere will disclose a primary infection sore in the immediate vicinity, while if the case be in either the secondary or tertiary stage numerous other indications will be present. Simple adenitis can usually be distinguished by the acuteness of the symptoms and the rapidity of its course. Sarcoma occurring in the glands is usually single, attain greater size, rarely suppurate, grow rapidly, and involve the surrounding tissues. Adenomata and lipomata are usually single, not multiple. Pseudo-leukæmia can be diagnosed from the fact that the glands in the other parts of the body are similarly affected, together with the other manifestations of the disease.

After all that has been said regarding the danger of a general infection of the system in this disease it seems hardly necessary to say very much in regard to the prognosis, as it is favorable early in the disease, and in such stages is amenable to successful extirpation. In the more advanced cases the prognosis is to be guarded, or even unfavorable. There can be no doubt but that the presence of infected glands are a constant menace to the patient, and early and thorough removal is the only treatment which should be advised; for while it is true that these glands may undergo suppuration and ultimately result in a cure, such a course is not a rapid one, is well calculated to favor a general infection, and is fraught with much danger to the life of the patient.

The treatment of this disease is, and properly so, almost entirely operative, since nothing short of removal of the infected glands can be looked upon as insuring immunity in the future. Of course, internal medication is a valuable adjunct, especially in individuals whose condition is such as would contraindicate immediate operation. A carefully-selected diet and every attention to the sanitary and hygienic surroundings are not to be neglected. But, as I have already said, I only intend to speak of the operative treatment.

Generally speaking, operation should be advised as early as possible in the disease, and from a surgical standpoint our prognosis will depend upon our ability to completely extirpate all the infected glands. Later in the disease the prognosis is less favorable, a more formidable operation is required, and the resulting scar is greater.

The operative treatment of this disease we may conveniently divide into three heads: 1. Caustery-puncture, or destruction by heat; 2. Scraping or scooping out of contents—curettement; 3. Excision. The first method I have never employed, the second I very seldom employ, while the third I always employ when possible. Of course, other methods, such as injection of iodoform emulsions and various other substances, have their advocates, but are not employed extensively and are of doubtful utility. So we will limit ourselves to the three first-mentioned methods and proceed to consider each more in detail.

Caustery-puncture consists in puncturing each infected gland with the fine point of a thermo-cautery heated to a red heat. Several punctures are made in different directions into each gland, after which a sterile and absorbent dressing is to be applied. This method is employed extensively by some of the English surgeons, notably Treeves. But inasmuch as I have had no personal experience with it, I am not in a position to criticise it knowingly. Apparently the object is to thoroughly destroy the bacilli by the heat, and then allow the wound to heal by granulation. What would appear to me to be more effectual would be the method which is employed in certain continental clinics—scooping out the contents and filling the cavity with sterile oil, which is then raised to the boiling-point by means of the thermo-cautery. But both of these methods appear to me as being unsurgical, and to be reserved only for such cases as are inoperable, which are very seldom met with.

The second method of curettement has a certain sphere of usefulness in those cases where the glands have suppurated and you are really dealing with an abscess; but scraping and scooping out are liable to lead to an infection of the surrounding structures. When employed, it must be thorough enough to remove all infected tissue and the lining membrane as well. Such cases should be allowed to heal by granulation, and should be kept under observation for a considerable period of time following the operation, to guard against possible recurrence of the disease.

Excision or extirpation is the operation which in my hands has been the most satisfactory. It is the most surgical of all

other operative procedures, is the most thorough, the safest, and leaves less scar than any of the other methods. The wound heals primarily, the convalescence is very much shortened, and after operation you can correctly judge as to what the chances are of a recurrence.

Excision is in many cases a very simple operation. If the affected glands are few in number, and especially if they be superficially located, the operation is easily accomplished, and attended by no more than the usual risks attached to any surgical operation. But, upon the other hand, if the number of glands affected are large, if they are located in the deeper tissues, and if they be possibly attached to important structures, as the large vessels, the operation is liable to prove exactly the reverse.

Every experienced surgeon recognizes the fact that when he enters upon an operation for the removal of tubercular glands from the neck he is to be prepared for one of the most serious procedures—an operation which is likely to prove both tedious and difficult—an operation which may involve very important structures. In many cases injury to the jugular vein cannot well be avoided. The carotid, vertebral and subclavian arteries are often exposed to view; the pneumogastric, phrenic and spinal accessory nerves may be uncovered, and when the deep glands beneath the clavicle and sternum are reached, even the innominate are close.

But even in prolonged operations—operations lasting two hours—the shock is usually comparatively slight. The secret to both success and safety lies in a free exposure of the operative field, enabling you to easily recognize the surrounding anatomical structures. The plan of some surgeons who operate through several small openings is not conducive to either safety or thoroughness. In many cases division and laying aside of the sterno-mastoid is essential for full exposure of the parts.

It seems hardly necessary to describe these operations in detail, nor to treat of the accidents which may occur. After making a free incision in the skin, gentle manipulations and the judicious use of a blunt dissector and blunt scissors will enable the glands to be shelled out one by one. When supuration has occurred and the glands become adherent to the

skin it is best to remove the overlying skin by an elliptical incision. And in such cases it is of the utmost importance to avoid dispersion of the tubercular elements among the healthy structures.

When the connective-tissue infiltration is great and the sinuses abundant a complete excision is impossible; but here excision of the superficial tracts is most serviceable, with free curetting of the deeper ones. Tubular drainage I never use, but occasionally gauze packing is employed; especially is this indicated if rupture of a caseous gland has occurred. If I am certain that my wound has not been infected, my plan is to close without drainage. I have a decided preference for aristol in all tubercular diseases, and it appears to have a very pronounced effect upon those cases which require packing and which must heal by granulation.

Should a recurrence occur another operation is to be advised, and should be even more thorough than the preceding one. Success is oftentimes only secured after repeated operations.

Those patients who refuse an operation should be frankly and plainly informed of the risks they run—that a non-operative course of treatment may result in a cure, but only after a long period of time, during which the patient is to assume the risk. Incision and curetting is to be very strongly condemned, excepting in those cases where complete excision is impossible. We should also bear in mind that the operative scar in these cases is much less than the suppurative scar. And, last but not least, we should always bear in mind that tuberculous lymphadenitis is a far more important and dangerous disease than many imagine.

PATHOGENY AND TREATMENT OF FUNCTIONAL OR CONCOMITANT STRABISMUS. Panas, Paris. (*Archives d'Ophthalmologie*, July, 1898.)—This author regards all of the cases of the above condition as being of peripheral origin, and due to high refractive errors and low visual acuity. His method of treatment varies but slightly from the accepted mode in this country of correcting the error, followed by tenotomy and prism exercise.

The principal difference in the radical procedure is that he stretches the muscle before cutting it. His method of operation is to sterilize the conjuction, make a small incision, pass the strabismus hook beneath the muscle in question, rotate the eye until the corresponding side of the cornea reaches the canthus, and then cut. As a rule, he operates on both eyes. The exercises are not commenced until some time has elapsed, the refractive error having been immediately corrected.

GALL-STONES AND ABSCESS OF LIVER.

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(Read before the Interstate Homœopathic Medical Association, Scranton, Pa., Oct. 11, 1898.)

THE subject that I have chosen for this occasion is one of the utmost importance not only to the surgeon but to the general practitioner as well, as no one in the practice of medicine will say that he has not been driven to his wits' end for remedies to control the pain in gall-stone colic, or a temperature which seemingly arises from a tenderness in and about the liver. It will not be necessary for me to enumerate the symptoms of gall-stone, for they are well known.

Diagnosis of gall-stone is of the greatest importance to the surgeon, as it would be very humiliating to open the abdomen and do a cholecystotomy for the relief of calculi and find nothing but bile in the bladder; so a positive diagnosis is always demanded by most patients, as most people will not consent to an exploratory incision. Now, you will say, How are we going to be positive? There is but one way, and that is to find calculi in the fecal discharges, and to find this we must not give up our search under a week after the patient has had an attack. This search must be carried out in the following manner: Collect each evacuation in a receptacle and add plenty of water, so as to make very thin; then strain through a very fine sieve, and if calculi exist they will remain in the sieve. If it be possible, put the discharges in a sieve and put under a hydrant, and in that way the process will be hastened. Of course, the usual symptoms will prompt you to do this; but if you do not find the calculi it is not proof positive that they do not exist, as in a case I have in mind where evidently none had passed, as one found was wedged in the common duct and had produced a suppurative process. In some instances, if a number of calculi exist, you may be able to detect the grating sound by the aid of the stethoscope. It often occurs that we have a septic condition, or rather what will be called a malarial condition,

and the gall-bladder will be at fault, an impacted calculi producing suppuration. In these cases we will have a condition of slight jaundice, also a tenderness in the region of the bladder. We may and we may not have chills or much rise in temperature in suppurative process of the liver, which I will show later. We have some symptoms which lead us to believe that we have a complete biliary obstruction, in fact, almost positive proof. They are pains in the regions of the gall-bladder coming on at intervals and in connection with jaundice; and possibly we may not have the jaundice, but we will have the persistent, clay-colored stools. We may not have the severe pain at all times. The clay stool above mentioned will prompt surgical interference. We must take a complete history of the case, in order to ascertain whether an external injury over this organ has produced an inflammatory condition, and by which means the duct has been closed. A careful history will eliminate this condition.

I operated on a case some time ago where the patient had had bilious colic for ten years, and yet no calculi were passed until about one week prior to operation. Still, when I opened the gall-bladder I removed fifteen gall-stones, which were smooth as pebbles picked up on the beach. The cause of this was, they were too large to pass through the common duct. We may have a single calculi, as in a case I saw some time since where the patient had not complained of colic but had of stomach trouble for a great many years. In this case we would have, at times, the clay-colored stools. When the gall-bladder was opened I found the calculi about an inch and a quarter in diameter and two inches long. Strange to say, in this case the calculi was very rough and pieces chipped off easily, but still there seemed to be no sandy deposit, as we would naturally expect in such cases.

The differential diagnosis between gastralgia and gall-stone is rather a simple matter, as in gastralgia we are not liable to have chill or much rise in temperature, whereas in gall-stone we usually get a decided chill and temperature from 102 to 103° F. In gastralgia the pain ceases more suddenly than in gall-stone, and we do not have the soreness in the region of the gall-bladder, nor the clay-colored stool and jaundice that so often accompanies the gall-stone. Of course,

it is not necessary to have jaundice to make a positive diagnosis of calculi. As I have said before, it is not necessary to have the clay-colored stool, as we may have small particles passing through the common duct, causing excruciating pain, but not obstructing the flow of bile; therefore, when the flow of bile is not obstructed we would not expect to get the above condition. Another disease must not be overlooked in making our differential diagnosis, and that is a malignant growth in or about the common duct. This, of course, could be distinguished by its slow onset, persistent pain, abdominal ascites, rapid emaciation, with the characteristic copper-colored skin and enlargement of liver. The age of the patient has a great deal to do with the diagnosis, as most cases of gall-stone develop between the ages of thirty and sixty-five. It is stated by pathologists, from their records of post-mortem, that in 25 per cent. of all females over sixty years of age they have found gall-stones existing.

When a positive diagnosis has been made and you are fully satisfied that gall-stones exist, you should not hesitate to advise the patient to undergo operation, for the mortality is so slight, and the old bugbear that surgeons used to put forth in connection with this operation, biliary fistulæ, is of so rare occurrence at the present time, and the pain that the patient suffers is not as great as a single attack of the colic; and this they have to suffer only once, whereas if the calculi is allowed to remain they are liable to recurrent attacks at any moment. There are two ways to perform this operation; one is, if the organ is free from pus and is in a perfectly aseptic condition after the foreign body has been removed, there is no reason why the wound should not be closed the same as we would do in an intestinal injury, and allow it to heal by first intention, that is, providing you are sure nothing remains undiscovered and that the common duct is open; but if there is a suspicion of a septic condition, the gall-bladder should be drawn out and stitched to the abdominal parietes and drainage placed therein and allowed to remain for forty-eight hours, or as much longer as it would be deemed advisable.

Abscess of the liver is a pathological condition that is often undiscovered; and it is not strange, for I can see how one can be misled, as it is usually considered to be a rare disease in this

part of the country, but in my opinion it is not as rare as authorities tell us. It is a very blind disease to diagnose, but when we have a trouble which simulates malaria, hydrothorax, or empyemia, which does not yield to treatment, we should bring all our forces forward in order that we may make a positive diagnosis. There is no great danger in introducing an exploratory needle in the pleuritic cavity or in the liver, if it is done in a cautious manner. Of course, we must do this operation with as complete a technique as if we expected to open with a knife. At first, if you do not find what you are looking for, you may introduce the needle several times. When introducing an exploring needle into the liver it is best to give an anæsthetic, so that your patient will not move, and possibly lacerate the organ and cause an internal hæmorrhage. It is also best to use a large needle, as at times the pus gets so thick it will not run through an ordinary needle, nor can it be drawn through with suction. We will, at times, find cases where we may come in contact with pus and evacuate a small quantity, and following this the temperature will drop to normal in a few hours, and lead us to think the trouble has been reached and overcome. But unfortunately this is not the case; this may come about by simply relieving the pressure for a time. We must not get the idea in our heads that it is necessary to have chills and high temperature in order to have pus imprisoned in this organ, for it is not necessary and it is very misleading, which you will see by a case I am about to report. The organ may not be enlarged or the side bulging, which, however, is usually the case. One symptom we will have is pain and tenderness upon percussion, also increased dullness; the pain may not be referred to the locality where the pus will be found. Of course the portion of the organ where the pus exists will have great bearing on the size and displacement. Jaundice is not an important factor; if it were present it would prompt one to think the malady near the common duct and the pressure was causing an obstruction. If the lower portion or the upper lobe is affected, we are not liable to get this symptom or clay-colored stools, but it may refer us to the lung for the real cause of illness, which of course would be misleading. We are liable to call trouble with recurring chill "malaria" without once thinking of anything else until we have reached our end of

remedies without benefit. The following case to which I was called in consultation will illustrate the obscurity of abscess of the liver and the necessity of a positive diagnosis.

Mr. G. W. P., age 42, was taken ill with what was diagnosed "la grippe." Had several chills; temperature of 101° ; complained of pain over the entire body; had some soreness in both lungs, headache, loss of appetite, thirst with the dry tongue. Was treated by an old-school physician for about two weeks, and seemingly received no benefit.

When Dr. Candee was called to the case, upon examination he found the above symptoms had existed and most of them existing at that time. He also found, upon examination, dullness upon the right side, extending in front up to about the tenth rib, and in the back the dullness seemed to extend two or three inches higher.

At this time the patient was coughing a great deal, having some night-sweats which were very exhausting. The skin and eyes appeared quite normal, tongue began to get moist after a day or two, bowel movement every day quite natural in color. He complained of a great deal of pain in the region of the liver and lower lobe of right lung. There was no bulging of the side; some pain in the region of the right kidney, which was tender to the touch.

Remedial agents did not seem to benefit him any after several days' trial, so the doctor thought there must be something about the case he had not discovered and asked me to go and see the patient with him. Of course the area of dullness at first naturally led us to believe that there existed hydrothorax, and I proposed that we give the patient an anæsthetic and use the exploring needle. The patient being anæsthetized, I put the needle in, back where the dullness seemed to be the most profound, between the tenth and eleventh ribs, and to my surprise I got about a drachm of pus, so thought we must have an abscess of the lung. The reason that I was surprised at getting pus, the patient was having no chills and very little temperature at this time, with scarcely any acceleration of pulse. I advised his removal to the hospital at once and the lung cavity opened.

He was removed about eleven o'clock that day, and at four in the afternoon I had him on the table and used the exploring

needle again, but to my surprise could discover no pus or fluid of any kind, so I did not feel justified in opening the cavity. At eight o'clock the temperature and pulse had dropped to normal. The persistent cough the patient had been suffering with for the past two weeks ceased and a good night's rest followed. Improvement continued for several days, until finally one morning the patient was found to be going backwards again. One day he would be feeling quite well, the next day he would be way down. At times he would have a temperature of 102° , then again it would drop down to 99° , some acceleration of pulse which showed a weakened condition of the heart. The perspiration returned, but the cough did not amount to much at this time. When he did cough he would simply expectorate a glairy mucus.

I was summoned again by the attending physician to look the case over, and I can assure you we were quite at sea regarding his condition. I advised giving the patient an anæsthetic again, and excluding, if possible, a lung trouble. The patient being anæsthetized, I again put a large exploring needle into the tenth intercostal space, posteriorly, and succeeded in obtaining some very thick pus, which was in about three inches. This time I made the diagnosis of abscess of the liver, again advised the patient's removal to the hospital, and at three o'clock of the same day operated. I made the incision about four inches long at the lower border of the ribs, but to my surprise the liver was so displaced upwards that I could not even turn the gall-bladder out. I immediately walled off the peritoneal cavity to avoid any accident, such as rupture of the pus-sac infecting the peritoneal cavity. I again proceeded to use my exploring needle, but to my great surprise was unable to obtain pus. I placed the patient in position so that I might put the trochar through the tenth intercostal space, posteriorly. No pus coming through the canula, I placed a large syringe on the canula, and with a great deal of suction succeeded in drawing some pus through, which was about the consistency of a cod-liver oil emulsion. I at once proceeded to take out about two inches of the tenth rib, so that I might have plenty of room to work. After a careful dissection I succeeded in liberating about twelve or fourteen ounces of very offensive pus. The patient at this point began suffering from severe

shock, but after the diligent use of saline solution, strychnia and whiskey for some four or five hours, the patient rested very nicely, and the following morning was in very good condition, as I had succeeded in getting very good drainage. Temperature normal, pulse 78, but an indication that the heart was not strong. I examined the heart, but could find no murmur. He continued to improve until the close of the third day, when all at once the pulse became very rapid, showing a weakened condition of the heart, the patient dying at the end of seven hours. I was very much at sea as to what the trouble was, as I could not attribute his death to sepsis, as there were no chills or rise of temperature. I demanded an autopsy, which revealed the following condition: The peritoneal cavity being the first to be opened, it was found to be normal. Next, examination of the liver was made, finding good drainage, absolutely no pockets or free pus existing.

I proceeded to examine the thoracic cavity, finding the left lung in a healthy condition, but the lower lobe of the right congested, and there was, of course, nothing left but the heart. Upon opening the pericardium I found it somewhat enlarged with a fatty degeneration, the left heart revealing nothing, the right an organized clot, which beyond question was the cause of death. Then I found, of course, the exact location of the liver, which had crowded upwards, right lobe enlarged so as to displace the diaphragm about three inches. You can see how easy it was to be misled and suspect the lung to be at fault. The abscess was found to be located in the middle portion of the right lobe of the liver, posteriorly.

Now nature had not located this abscess in a place so convenient that it might rupture in the stomach or in the lung and be evacuated in that way, as often occurs. It can be plainly seen that in the treatment of abscess of the liver it should not be left with the idea that it will rupture in some convenient place, so that operative procedure will not be necessary. Of course you will say that this patient died, anyway; but it was a desperate case and absolutely the only chance to save the man's life, and it can be plainly seen by the autopsy that death was not the result of operation.

In my opinion we often have death following surgical procedure where the operation has nothing to do with it, but some condition of the heart same as existed in this case.

A PLEA FOR THE APPLICATION OF BETTER SURGICAL PRINCIPLES TO
THE TREATMENT OF FRACTURES.

BY G. MAXWELL CHRISTINE, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society, State of Penna., Pittsburgh, Sept., 1898.)

ONE of the serious questions confronting the surgeon is the treatment of fractures of bones. In spite of the fact that the setting of fractured bones was quite an art in the earliest history of surgery, it would seem strange that at the present day this subject should be debatable. And yet we find the profession has not considered that our methods of treatment in fractures have reached their possible acme; for now and then a new method to secure fractured bone union is exploited, or an old and obsolete method is resurrected and advocated in its entirety or with modifications. I feel quite sure that no surgeon is satisfied that he has no need to improve upon his method of treatment of fractures. If he does, it fails of accord with the past history of the art, which seems to be ever seeking toward more perfect method and the securing of better results, which is a confession of imperfection. Nor need we be surprised nor especially chagrined that fracture treatment has not kept pace with other surgical advances when we consider the attendant difficulties.

The trouble with us is largely that we do so little independent thinking and acting. It appears to require an extraordinary amount of bravery on the part of a surgeon to depart from the classical methods in fracture treatment. Opinion has become set on the methods of the forefathers, and it is very difficult to convince some that it is possible to learn anything new in the treatment of fractures. We are strong in breaking out of the bounds in other surgical work, but in fractures we go in the track laid out for us by others as though it could never be improved upon, and no other existed. We are content to rest on the old-time statement that certain fractures must inevitably result in loss or diminution of function, without stopping to think as to whether we ourselves cannot modify such results in favor of a better condition, or whether the time may not arrive

when fractured bones may be treated with as much success in coaptation and primary healing as we get in a wound—as, for instance, the evanescent wound stitched by a subcuticular suture. Why should we demand perfect work in the treatment of a wound of the soft tissues and not expect it of a fractured bone, when the conditions are at least alike of no loss of structure, the absence of sepsis, intimate coaptation, etc.? The surgeon will open the peritoneal, cerebral and joint cavities with complacency and impunity, and will tell you that if nothing pathological is found there the wound can be closed with no ill-effect. The technique has so far improved that exploratory incision almost anywhere in the body can be made with practically a *nil* result, though yet even here our methods admit of improvement. Then why do we stand aghast at a fractured bone and tremble at fear of the result? We have simply permitted ourselves to be wedded to tradition. Many there are who regard fractures as necessarily productive of deformity, somewhat like the opinion held by the old surgeons who, when a wound discharged pus, gloried in the fact that healing was going on so beautifully. If a tendon ruptures or is severed we cut down and suture; if a finger-end is cut off we stitch it on again and hope for a cure; if for any other cause the gut is resected we rejoin the cut ends—all of which is done by direct contact with the part. But when a bone is broken, we are afraid to get down to it and apply our treatment direct. The reason partly resides in adherence to unsafe and often unsound traditional guides, but mostly in a lack of faith in our surgery. It is to strengthen this faith and to engender confidence in the means our art furnishes us, by pointing out a few of our errors, and indicating wherein we can safely and advantageously call to our aid those surgical principles which have just as much right of application to bone-fracture healing as to any other surgical condition, that this paper is written.

Suits against physicians for malpractice have been confined almost solely to fracture cases, and while the courts have justly stood by the physician who conscientiously applied the means at hand to the treatment of the fracture, even though deformity result, the fact is based upon a principle held to be a good one by the laity, but not altogether by the profession, namely, that a bone fracture properly treated should result in an entire

absence of deformity. The people expect perfect work; the surgeon denies that it can be secured in all cases, and even prepares the people to expect deformity or limitation of function by stating the probability of its occurrence. It is unfortunate that the conscientious surgeon is obliged to fortify himself against attack by a statement, the utterance of which is a confession of incompetence; but this confession is made even among ourselves, it is testified to in the courts, it justifies us in our poor work, and is the miserable excuse for our unsuccessful attempts. So long as our profession is hampered by the machinations of shyster lawyers, and so long as juries do occasionally mulct us in damages, it might be well for us to be wary; but here among ourselves let us seek to perfect our methods so that we shall have no occasion for an excuse which, respecting our other surgery, would in the light of our present highly-perfected art and skill, be regarded as absurd.

The old method of treating bone fractures in a sort of "sight unseen" manner, trusting largely to good fortune for a good result, will, I trust, be replaced by the common-sense method of cutting down to the fracture and acting according to the conditions there found—not that it should be done in all instances in which no doubt whatever exists as to accurate reposition of fragments and their certain retention in normal continuity, but always in those many doubtful cases of fracture in which uncertainty exists as to proper setting, or reduction, the maintenance of the desired union of the fragments and the immobilization of the parts.

Just as I am writing, the *Philadelphia Medical Journal* for September 24th is handed me, and I find from the pen of Dr. Roberts, of Philadelphia, a strong article on subcutaneous nailing, exploratory incision, and the extended elbow in condyloid fractures of the humerus, which I have read, before proceeding with this article, with so much interest that I must mention Dr. Roberts' salient points as being more forcible than any I could give you. They come from an original thinker and actor in fracture surgery, and I bid you give them careful consideration, because they so appealingly argue for a better surgery than that of the past or present. Dr. Roberts confines his remarks to the elbow, but they are applicable elsewhere in the body, and I believe even to the hip, that present almost

forbidden locality in time of fracture. The paper of Dr. Roberts contends:

1. *That ankylosis of the elbow-joint after condyloid fractures is usually due to imperfect reduction of fragments or incomplete restitution of structural relations.*

In support of which he states that "the interference with mobility results largely from distinct alterations in shape of the articulating surfaces, due to incorrect coaptation," etc. He closes his argument on this point by remarking that "displaced bone causes ankylosis, and that incision at the time of the reception of the injury would probably have permitted restoration of bony contour and prompt recovery of functional activity."

2. *Conservation of the normal angle between the axes of the humerus and the ulna is desirable.*

He refers to the causes of "gunstock deformity" as due to fracture of one or both condyles of the humerus. I quote a sentence on this point: "It is an acknowledged duty of the surgeon to restore, after injuries, the anatomic symmetry, as well as the functional usefulness. Hence, no extended argument is necessary to prove that it is best to adopt that line of treatment which will attain both ends. *Retention* of the normal humero-ulnar angle of a broken elbow is, therefore, not only desirable for cosmetic reasons, but is demanded by anatomic and surgical considerations."

3. *Fixation is satisfactorily obtained by nailing the fragments together with long nails driven through the skin.*

On this point Dr. Roberts refers to the possibility not only of incomplete reduction of the fragments, but to imperfect fixation "which has allowed the properly readjusted fragments to slip again into abnormal relations." He quotes Stimson, who says that "the impossibility of direct control of the fragments, the contraction of muscles and the pressure of fascia combine to make the result largely a matter of chance. This opinion was confirmed, he states, by seeing and feeling in open fractures the difficulty caused by the shifting of the fragments."

Dr. Roberts then passes on to the relation of experiments performed showing that "fractures of the condyles of the humerus, made in the cadaver, can be satisfactorily fixed after reduction by driving wire-nails through the skin into the bone and across the lines of separation." Skiagraphs are given showing experimental fractures kept in position with wire-nails driven through the skin. Dr. Roberts had special fracture-nails made of "tempered steel with a drill-shaped point and a long, square head. These nails are driven into the bone, and are pulled out in two, three or four weeks." After the fixation

by means of the "fracture-nails," an aseptic dressing is applied, which may or may not be supported by a splint of wood, metal, paper, or gypsum.

These nails will be easier of application in open fractures, and if sufficient information is not obtainable as to the position of the fragments by the X-ray, palpation, etc., exploratory incision is the safest course in severe injuries of obscure character.

Under a fifth point Dr. Roberts has this to say: "Aseptic incision of joints, being in competent hands practically free from risk to life, is demanded in a certain number of elbow-fractures, because the anatomic integrity of the joint and its functional usefulness are jeopardized by the surgeon's ignorance of the lesion and his consequent inability to repair the structural damage." "The patient with a bad fracture of the elbow has an intrinsic right to the benefit derivable from incision in competent aseptic hands." The rest of Dr. Roberts' article pertains to position of the arm, etc.

I refer so fully to this paper because it comes to hand at so opportune a time, when I needed a few strong sentences from an authority to support my contention that there are occasions when it is demanded of us to cut into the bone to be able to know what we are doing, and, finally, as to how well it has been accomplished. But, let me refer to another paper, namely, that of Dr. Allis, also of Philadelphia, on "Open Measures in the Treatment of So-called Simple and Compound Fractures," which appeared in the *Annals of Surgery* for June, 1897. I would like to quote extensively from this article, and limitation as to time only prevents. I cannot refrain, however, from reading to you a few sentences: "What is the condition in an injury to the leg with both bones broken, but the skin intact?" "Laceration of periosteum, deep and superficial fascia, outpouring of blood between the fragments and muscles, displacement of bone fragments." . . . "Open up the part with a free incision, carefully divide the deep fascia to the full extent of the seat of fracture, or, better, to the full extent of the external wound; then cleanse the wound of clots, ligate bleeding vessels, repair injured nerves, wire or directly mobilize the fragments, dress without suturing, and encase in plaster."

Dr. Allis does not advocate this method in all simple or closed fractures, but he urges that "very many so-called simple fractures are as grave as the more dreaded compound fractures, and cannot possibly be scientifically treated by any other than

open measures." Dr. Allis then states that "whoever treats a fracture with unbroken skin must confess that he has treated it ignorantly." He refers to several cases of fracture ending in deformity, but subsequently examined by incision, in which the cause of deformity was found to have resided in "muscle interposed between the fragments, a condition that could not possibly be detected by palpation and manipulation at the time of setting the limb," though done under an anæsthetic.

I quote these authors to demonstrate the fact that surgeons are thinking, that they are beginning to diagnose their cases more carefully, and are putting into execution sound surgical principles which they have long known but have been ignoring in the treatment of bone fracture, or have been too timid to apply. I have met many instances of deformity which, in the light of the surgery I am advocating, were needless; and I, myself, must account to my conscience for errors of omission as well as commission in similar cases. I present a skiagraph I have taken of an ancient fracture which, if the method here advocated of cutting down to the seat of injury and by some mechanical means keeping the bones in apposition had been adopted, would not have resulted in the deformity shown. Let us have less fear of the result of this exploratory incision, and in each case of fracture concerning which we have doubt let us get a little closer to the surgical precept, "when in doubt, operate!" and our fracture surgery will take a great advance. If we have the surgical trend, and know how to do surgical work, we need have no fear of harm following the mere fact of incision. Having reached the seat of fracture and reduced the fragments to their normal positions, of course freeing the parts of escaped blood, spicules of bone, etc., and having untangled interposed fascia, muscle, etc., our next duty is to fix the bones in place.

We should suture or bring together, by some mechanical means, the ends of a fractured bone, and I believe that this union should be as intimate as it is possible and practicable to make it.

The ingenuity of the mechanical surgeon has ever been taxed to determine the best way of doing this. Suture materials and clamps of all kinds, from catgut to silver wire, have been employed for this purpose. Nailing of the fragments together has

been tried, and I have already quoted Roberts in this respect, though the idea is, of course, not new. Bones have been joined with ivory pegs, and attempts, sometimes successful, have been made to hold the ends of bone together by stitching the periosteum. Malgaigne's hooks and various screws are crude attempts to secure the close apposition of broken bones, their fixation in the normal position and relation, and a union *per primam intentionem*. I suggest here that Malgaigne's hooks are not such bad things as they are generally regarded.

It is an acknowledged fact that much of the infection in closed wounds comes from the sutures, starting as stitch abscesses. Effort has frequently been made to overcome this by doing without sutures, and many devices have been put forth to take their place. Thus far, I believe, none of them have been successful. The same strenuous effort has been manifested concerning sutures for bones. There is no form of suture or nail or screw that passes through the bone wound that is not considered objectionable. They are all foreign bodies, and are not easily tolerated by the tissues. Following out this idea, a bone-clamp has been devised by Dr. Clayton Parkhill, and referred to in an excellent illustrated article by him in the May number of the *Annals of Surgery* for this year. Dr. Parkhill says that "Modern surgical technique should now be sufficient to warrant a bolder method when necessary, and the securing of accurate and permanent fixation of the fragments." He then describes a bone-clamp which he has used. "It consists of screws, curved wing-plates and clamps to hold them in place. Holes are drilled in the bones, the screws inserted, the wing-plates applied, and the clamps added and tightened." The instrument is described as "simple in construction, easy and accurate of adjustment, and when properly used secures absolute fixation of the fragments."*

This clamp has been used by Dr. Parkhill and others in such cases as pseudarthrosis of the humerus and of the femur, delayed union of bones of the leg, pseudarthrosis of both bones of the forearm, recent fracture of both bones of the leg with tendency to displacement, malunion of the femur, pseudarthrosis

* A set of these clamps, made for Dr. Christine by The Charles Lentz & Sons Surgical Co., was exhibited, and the *modus operandi* explained.

of the tibia, malunion of the humerus, fracture of the radius, and fracture of the patella, with great success. Dr. Parkhill claims for his clamp the following :

1. That union has been secured in every case in which it has been used, as against 50 per cent. of cures by all mechanical means, according to the statistics of Bruns and Gurlt.
2. That it is easily and accurately adjusted.
3. That it prevents both longitudinal and lateral motion between the fragments.
4. That the presence of the shafts in the bone stimulates the production of osseous tissue.
5. That nothing is left in the tissues that might reduce their vitality or lead to pain and infection.
6. That no secondary operation is necessary.

I would add a very important claim, namely, that the bones are brought together without any part of the mechanical device being in contact with the bone wound, the screws being put in at a distance from the break, and the wound of the soft tissues closed or left open, as may be desired or required.

The conclusions to which I would have your attention fastened are as follows :

1. If proper adjustment cannot be secured and maintained by the ordinary methods of splints, etc., the bone should be cut down upon, and effort made to secure this result by manipulation of the bone direct.
2. Mechanical devices are sometimes necessary with which to fix the bone fragments in proper coaptation and to maintain them in alignment.
3. All devices which come in contact with the bone-wound are obviously objectionable.
4. All mechanical devices requiring secondary operation to remove are likewise contraindicated. The Parkhill clamp is simply unscrewed.
5. Clamps, such as that of Parkhill, seem to fulfill the requirements in the many instances demanding a device of this kind.
6. Bone-surgery is amenable to the same laws as the surgery of other parts; hence we should be readier to cut down upon fractures than is now the case, observing, of course, the necessary aseptic technique.

EDITORIAL.

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ANTI-CRAMMING.

Not only in a general way, but in many specific directions, has the medical profession looked after the welfare of children. It has sought, by writings and lectures addressed to the laity, to mould pre-natal influences so that the children may be as well born as possible. It has taught how to "modify" the artificial food of those deprived of their natural nourishment, so as to enable them to survive at least the digestive dangers of infancy. It enters the kindergarten and prescribes the number of minutes to be devoted to each occupation, so that the little tots may be helped up the hill of knowledge without fatigue. In the school-room it examines their eyes, and sometimes their ears; it looks into their throats, and vaccinates their arms; it gives them individual drinking-cups, and forbids the exchange of slate-pencils, and thus seeks to watch over their physical well-being. Here, however, it seems to halt, and, at the most critical period in the development of the young organism, its efforts are relaxed and it looks with seeming indifference upon abuses more potent for permanent damage than any it has so persistently sought to suppress; we mean the system of cramming, so universally prevalent in our public schools.

Here and there individual physicians have raised their voices against the amount of study demanded of boys and girls about the age of puberty, but the profession as a body should rise up and demand a reconstruction, on rational and hygienic lines, of the curricula of our public schools. In some private schools and in many of the higher institutions the same abuses exist; but in them the individual physician, through representations made to his patients, the patrons of such schools, can bring his influence to bear. In the case of the public schools, however, on account of their independence of patronage, nothing but a united medical public opinion can hope to have weight.

The fundamental purpose of the public school seems to have been entirely lost sight of. It is no longer an institution in which the children of those unable of themselves to provide for their education may receive sufficient knowledge of the essentials of a common education to enable them to take their places as good citizens. Their needs are answered by a good knowledge of the three R's, and the large majority of those who have a right to be scholars in the public schools have no time for anything more, and only a limited time to devote to the acquisition of this. The curriculum should be arranged with regard to the want of these, and the padding with all sorts of other knowledge, imperfectly and with difficulty acquired, and soon forgotten, is irrational and unjust, since it necessarily extends over a longer period than they can spare the presentation of those branches which alone are of interest and importance to them. We see this exemplified daily in the withdrawal from our schools of those who are compelled by the circumstances of their parents to become wage-earners, with an imperfect knowledge of what should be essentials to them, and an equally superficial smattering of subjects for which they will never have use and upon the non-acquisition of which their valuable time has been wasted. In spite of this deficiency, from our present point of view they are to be congratulated on having escaped, in a measure, the serious consequences of the more vigorous cramming process which would have awaited them, and which bears so heavily upon the more ambitious and more unfortunate ones who are obliged to continue at school. Any one may convince himself that we are not exaggerating if he will take the trouble to inquire as to the number of studies taught and the number of hours of home work required of children from the age of fourteen up. He will find the number of unessential branches constantly increasing, the weight of books to be carried in the arms to and from school and the amount of barren knowledge to be crammed into the heads ever greater, and hours for home study ruthlessly encroaching on time which should be spent in recreation or amusement. Just at a time in their young lives when all the energies of their physical nature are concerned in the supreme effort to develop the immature being into the mature, when the nervous system is rendered most tense in nature's efforts to attune it to new

impressions and higher emotions, the demands of our higher public school education, as voiced in the curricula of the grammar, high and normal schools, divert and dissipate their activities.

Is it any wonder that so many graduate into typhoid fever and chronic invalidism, or that so often the graduating gown becomes the cerements of the grave? If, on the part of those who stand at the head of our various educational boards, there was a fuller appreciation of the physiological changes which accompany puberty, not limited to the occurrence of pimples and backache, we might hope for a more rational regard for the healthy development of the rising generation.

Each new incumbent of a responsible position in our educational affairs seems to feel bound to justify the wisdom of his choice by the introduction of something new, a new study or a new method, the sole result of which is usually only still further to burden the teachers and to mystify the scholars. Our only hope is that the medical profession as a body may take up this subject and raise a warning voice against the inevitably disastrous effects of the present system, and that some educator may thereby be encouraged to stem this frothy inundation of ever-widening curricula, and confine again within its legitimate banks the placid but deeper flow of knowledge in our public schools.

WORTHY OF IMITATION.

FROM the "Report of the New York State Board of Medical Examiners" (old school), besides the fact that 29.9 per cent. of the applicants before the board were refused licenses in the past year, we learn that the faculties of the various medical schools have been asked to furnish thirty questions on every branch taught in those schools for the use of the question committee.

This is surely a step in the right direction, and one which agrees entirely with our own views. In an editorial last August we said, in suggesting some changes in the present system of State examinations, that these "would obviate what seems to us, under the present system, to be every year a more imperative

necessity, viz., the co-operation of the teaching bodies in the selection of questions, if justice is to be done to the candidates."

This action in New York is a good omen. It seems to show a better appreciation of the true situation, not only from the point of view of the examiners, but also from the standpoint of the colleges and of their graduates. It is, in our opinion, the only way in which the present system can be rescued from deserved opprobrium, but it presupposes a recognition of the integrity and honesty of the college professors; and such is, alas! not a prevailing epidemic, and is, indeed, here in Pennsylvania, conspicuous principally by its absence.

It is a pity this should be the case, but it is possible that it might become different, and that mutual confidence might be engendered if the State examiners here were to inaugurate, only tentatively at first, some such co-operative action as that introduced in New York.

SUPRATONSILLAR FOSSA AS THE STARTING-POINT OF INFECTION.—The lymphoid tissue forming the inferior boundary of fossa is softer; in looser connective tissue or stroma crypts or lacunæ (normally) are larger and opening wider, and the surface is extended by finger or teat-like projections; therefore the lymphoid glands are probably more active in this location, and absorption takes place more freely here.

The normal excretions of the follicles may be dammed up in the fossa by obstruction of its outlet, as also food particles may; these disintegrate, and the overactive follicles absorb the toxins from them. Lachrymal tonsillitis following nasal operations (as well as ordinary attacks) usually commences in the upper portion of tonsil; this more probably due to the catching of the nasal discharge following operations in the fossa than the communication through the lymphatic channels from the nares to the tonsil. Experiment was made; free drainage and cleansing of fossa were made previous to operation and no tonsillitis followed. In these same subjects tonsillar sequelæ had manifested themselves after nasal operation. As peritonsillitis occurs in the cellular tissue in contact with this space, it also probably comes from infection from decomposing material in this space.

A comparison of the frequency of inflammation of the faucial tonsils with the same of the lingual or Luschka's—it being so much more so in the former—the author holds, shows the importance of this fossa, because there is no similar space connected with the other tonsils.

"Septic pharyngitis," or hospital sore throat, also commences in the upper part of tonsil. Pharyngo-mycosis and tuberculosis may also start in this space.—*The Lar.*, 1898.

GLEANINGS.

USE OF ALCOHOL.—Dr. Clauston, of Morningside Asylum, Edinburgh, says no one should use *alcohol* :

1. Who has any family history of drunkenness, insanity, or nervous disease.
2. Who has used alcohol to excess in childhood or youth.
3. Who is nervous, irritable, or badly nourished.
4. Who has suffered from injuries to the head, gross diseases of the brain, and sunstroke.
5. Who suffers from great bodily weaknesses, particularly during convalescence from exhausting diseases.
6. Who is engaged in exciting or exhausting employments, in bad air and surroundings in workshops and mines.
7. Who is solitary or lonely, and requires amusement.
8. Who has little self-control, either hereditary or acquired.
9. Who suffers from brain weaknesses, the result of senile degeneration.—*Quarterly Journal of Inebriety*.

BACTERIOLOGICAL STUDIES OF BRONCHITIS.—Dr. I. Jundell, in an exhaustive study of the bacteriology of bronchitis, using methods that exclude contamination with bacteria of the mouth and throat, concludes that acute bronchitis is not always an infectious process; at least with our present methods we cannot demonstrate the presence of germs. This is often the case in bronchitis from cold, and even in bronchitis with grippe-like symptoms. A number of cases of acute bronchitis are, however, infectious. The infectious agents are not the usual pus-producing cocci or pneumo-cocci, but either or partly the streptococci of mucous surfaces, the germs of the grippe or allied germs, or the meningo-coccus intracellularis.—*Hygieia*, Nos. 6 and 7, 1898.

TÆNIA IN CHILDREN.—Dr. Sassy advises in tape-worms in children the following formula: black oxide of copper, 5.0; prepared chalk, carbonate of magnesia, aa 1.0; gum of tragacanth, 10.0; glycerin, 5.0; white sugar, 40.0; water sufficient to make fifty tablets. From two to three a day. This remedy is to be tried in those cases where in spite of all other drugs the worm recurs. The oxide of copper is not toxic.—*La Settimana Medica*, No. 33, 1898.

FAMILY NERVOUS ŒDEMA.—Dr. Meige, of Paris, at a recent meeting of the French Congress of Alienists and Neurologists, exhibited the photographs of eight members of a family who were affected with the same variety of œdema. It was a whitish œdema, hard and indolent, occupying sometimes the legs, sometimes the whole of both lower extremities, and appearing in all the patients between the twelfth and thirteenth years. In one of them, aged 17 years, who is hysteric, the œdema only affected one of the legs. In all the others it was bilateral. He regards it as a family dystrophy.—*La Semaine Medicale*, No. 43, 1898.

TREATMENT OF HÆMORRHAGIC NEPHRITIS.—Prof. Kraemer advises the use of methyl-blue in cases of chronic hæmorrhagic nephritis, where the traces of blood disappeared under the use of the drug in four such cases. The albumin was also greatly reduced, and in a short time the general state of the patient decidedly improved. The favorable influence of methyl-blue has been emphasized by Netschajew. Lemoine also obtained good results with it in seven cases of nephritis. Einhorn and Dehio found it efficacious in cases of pyelitis.—*La Settimana Medica*, No. 32, 1898.

TO REMOVE FOREIGN BODIES FROM UNDER THE NAILS.—Soften the nail with a 10 per cent. solution of caustic potash applied with a toothpick and then scratch off the softened nail with a piece of glass; apply the caustic anew until the foreign body is reached.—*Ibidem*.

TACHYCARDIA IN TUBERCULOSIS: ITS DIAGNOSTIC, PROGNOSTIC AND THERAPEUTIC IMPORTANCE.—Dr. Faisans, of Paris, directs attention to the significance of the pulse in tuberculous subjects. A fast pulse in this disease is suspicious even without febrile signs of tuberculosis. Prof. Lasogue twenty-five years ago called attention to this important sign. Such a patient has a pulse of 90 on waking, 100 after eating, and 110–120 after a walk. Though varying in intensity and duration there is generally an accompanying dyspnoea and palpitation. The sense of oppression of consumptives is of cardiac origin—usually. Coughing-attacks tire and cause dilation of the weakened and emaciated myocardium with yielding of the right heart. Cachectic œdemas of the final stage are generally due to acute asystolia, from fatiguing coughing. Instable tachycardia is characteristic of eristhetic forms of tuberculosis. Compression of the vagus from enlarged tracheo-bronchial glands is the cause, in a number of cases. Usually, however, the action is central and due to the tuberculous toxine. In numerous cases he has by means of a tachycardia been able to diagnose a latent tuberculosis from six months to a year before the disease became manifest. For example, a man of 30, formerly well, after a violent emotion, suddenly in two months lost forty pounds. His pulse was 100, there was a sense of a little pressure on the chest, and he became a little more easily tired than generally. Otherwise, nothing abnormal; his digestion was in order; his thorax and urine were normal. A year after, during which the emaciation became extreme and the tachycardia persisted, a dry cough developed. Pulmonary tuberculosis of the right upper lobe rapidly developed within three weeks, while the previous examinations of several physicians had detected nothing abnormal in the chest. The prognosis in such cases is, of course, gloomy; the course is sudden.

Therapeutically, large doses of creasote are dangerous, in tachycardia. All excitants, stimulants as kola, coffee, tea, alcohol, are also injurious. After numerous experiences he has found digitalis as worthless as spartein, strophanthus, secale and tannin. All preparations of opium increase the heart-hurry. Bromide of potash acts in some cases, but its influence is transitory and depressing. In some cases, with tachycardia and considerable hæmoptysis, he has seen an astonishingly promptly sedative and hæmostatic action from this bromide after failure of other drugs (2–3 gms.). In tuberculosis, whether suspected or frank, one should watch the pulse. In tuberculous women before menstruation, the heart-hurry is prone to increase. Complete rest and quiet are indicated.—*Hospitalstidende*, No. 32, 1898.

A CASE OF MALINGERING ; SIMULATED CHYLURIA.—Dr. Casper relates the curious case of a young man of 23 years who appeared to be in comfortable circumstances financially, and who claimed that for two years he had suffered from intense pains simulating renal colic. Palpation of the region of the kidneys revealed nothing abnormal. The urine when examined was found to be always turbid, acid and full of albumin and fat, but when drawn by the catheter was wholly clear and normal. The deception was detected as follows : While 500 cems. of boric acid solution were injected into his bladder a solution of the iodide of potash was added to a bottle of sour milk which had been discovered in his pockets. This done, he was instructed to urinate. The boric acid solution which he then expelled from his bladder contained fat and yielded the reactions of iodine.—*Anales del Circulo Medico Argentino*, Tomo XXL, No. 10, 1898.—Some time ago I saw a queer specimen of urine in the office of a neighboring practitioner. A hysteric woman had added corn-starch to her urine and had brought it to her physician for examination. The fraud was detected by examining the whitish sediment under the microscope and by the well-known bluish reaction of the starch with tincture of iodine. The mixture of urine and starch was first boiled before adding the iodine. On another occasion this patient had put cane sugar into her urine to deceive.

HYSTERIA IN A CAT AND A CANARY BIRD.—Dr. H. Higier, of Warsaw, records two instructive cases of hysteria in animals :

A cat of 9 months, which had been healthy and lively, was one day attacked by a dog and bitten in the back. The cat at once fell over and lay as if paralyzed. Six weeks later there were paralysis and anæsthesia of the posterior extremities, the posterior portion of the body, the legs as well as of the tail. There was neither atrophy nor incontinence of the bladder nor rectum. A traumatic myelitis was thought to be the cause of these symptoms, but by an accident the right diagnosis was made.

A servant girl came upon the idea of throwing the cat out of a second-story window in order to see if it would fall upon its feet as other cats do when thrown from a height. Surely enough, it fell upon its feet, ran about, and was instantly completely cured of its paralysis. The writer thinks that the disease might be explained as of hysteric origin.

The second case was that of a canary bird. A cat had sneaked into a room and thrown down a cage with a canary bird therein. The mistress ran into the room and the cat escaped without having touched the bird. The bird lay as stiff as if dead upon the floor of the cage. It gradually came to and was soon as lively as ever again. But it, formerly a brilliant singer, had suddenly become dumb. After six and a half weeks it suddenly began to sing again. In this latter case the writer assumed that there could not have been any organic lesion, but a hysteric paralysis of the vocal cords from the fright—aphonia hystérica. He cites two similar cases in dogs from "Gilles de la Tourette."—*Norsk Magazin for Lægevidenskaben*, No. 8, 1898.

THE DIFFERENTIAL DIAGNOSIS OF ARTERIAL, MENINGEAL AND GUMMATOUS SYPHILIS.—Drs. Teissier and Roux, while admitting that there is no symptom which is pathognomic of any of these three varieties of cerebral syphilis, yet from an analysis of the symptoms, their grouping and development, one may occasionally diagnose the anatomical variety of the specific lesion.

The principal characteristic of syphilis of the arteries of the brain is that, with the phenomena of deficiency and irritation, the former predominate. Therefore, one observed more frequently flaccid paralyses with abolition of the reflexes; still rarer is partial epilepsy. Trembling, choreic movements, while not at all infrequent in other forms, are here exceptional. Headache may be present, but not as often as in meningeal and gummatous syphilis, and it is more diffuse. It is not aggravated by pressure and percussion of the cranium. Choked disc and optic neuritis, which are common in the other varieties of brain syphilis, are rare. Paralyses of the ocular nerves are also infrequent. There is no active delirium; there is rather a progressive depression of all the intellectual faculties.

The chief characteristics of meningeal syphilis are: flaccid paralyses rarely met with; they are incomplete, more often, and always associated with rigidity and contractures, exaggerations of the reflexes; partial epilepsy is frequent. The headache is almost constant, which may be in one case localized and in another diffuse; it is aggravated by pressure. There are sharp pains of central origin; illusions are frequent, as well as neuro-retinitis, with pronounced inflammatory phenomena and violent, active delirium. There is no remarkable weakening of the intellectual faculties.

In gummatous syphilis, *i.e.*, where the gumma is situated in the depths of the white substance, the symptoms are deficiency and irritation, and essentially those of cerebral tumors. The antecedents, the history and the results of specific treatment will be of service in diagnosis.

In short, in cerebral syphilis one has to distinguish between that of the arteries and of the meninges; the gummatous variety is to be differentiated from other kinds of brain-tumor.—*Archives de Neurologie*, vol. v., 2d série, Nos. 25 and 26, 1898.

NERVOUS SYMPTOMS OF URÆMIA.—Dr. Fuerstner calls attention to the lack of knowledge of the state of the pupil in uræmia. It has been said that in the uræmic convulsions they are dilated and contracted in chronic uræmia. The reflexes have been but little investigated. From investigations, he finds the pupils to be dilated before the seizure; contracted then, to dilate during it; after which they become immobile. The patellar reflexes exaggerate after the attacks, while the cutaneous diminish. In two cases observed, one a man and the other a pregnant woman, whenever the convulsions were imminent the pupils always contracted and the tendinous reflexes augmented. Concluding, he points out the serviceability of watching the pupils and reflexes in threatening uræmic seizures.—*La Settimana Medica*, No. 42, 1898.

URÆMIC SALIVATION.—Dr. G. Mouttier, in a "Thèse de Paris," points out the symptomatic value of this sign in chronic nephritis, which is often accompanied by stomatitis and gastro-intestinal alterations, though the organs need not be involved symptomatically. A safety-valve, in a measure, though insufficient, it replaces somewhat the faulty renal excretion. Diagnosis is difficult: it must be distinguished from nervous sialorrhœa, and that of various infections and poisonings, *if gastro-intestinal disturbances be absent*. To detect the uræmia in its incipency, one should recall the minor symptoms of Bright's disease described by Dieulafoy, abstracted in the *HAHNEMANNIAN MONTHLY*, No. 1, 1894, p. 54. In these cases do not attempt to stop the salivation; for it replaces the action of the kidneys, in a way.—*Revue Generale de Pathologie Interne*, No. 17, 1898.

TREATMENT OF GONORRHOEA BY INJECTIONS.—Prof. Unna, of Hamburg, thinks it a mistake to inject in gonorrhœa only during the day, while during the night, when the patient neither urinates nor injects, the suppurative process rapidly progresses. Indeed, in the morning the gonorrhœal process is always most active and pronounced. He recommends such patients to inject at least twice a night, using an alarm clock, if necessary. (A very noisy clock might awaken their mammas.) In very acute cases he advises injecting day and night every two hours, and when there is no "morning drop," every three hours. The next week then every four hours, the one after that every five hours, and thus decreasing the number of injections, "tapering off," until once a day. In long-lasting treatment by the patient himself, he should always remember that he is only convalescent and beware of recurrences and reinfection. As an injecting fluid he recommends: Zinc. sulfocarbolate, 1.0; resorcin, 4.0; aqua fœniculi, 2000.—*Wiener Medizinische Presse*, No. 33, 1898.

THREE CASES OF GUNSHOT INJURIES OF THE ABDOMEN HEALING UNDER EXPECTANT TREATMENT.—Dr. Froelich, of Stettin, reports three such cases:

1. A young man of 16 years carelessly shot himself with a pistol of six mms. calibre in the epigastrium. The ball entered four cms. from the median line, three cms. under the costal arch. The pistol was pointed perpendicularly downwards, with the mouth of the weapon about ten inches away from the abdominal wall. Two hours after, he was transferred to the hospital. There were nausea, sensitiveness to pressure over the wound and painfulness on breathing. Although the stomach was assumed to be perforated the patient was given expectant treatment and absolute diet. As under continuous surveillance no untoward symptoms appeared, neither in his general condition nor in the peritonæum, he was left alone. He recovered fully.

2. A man of 36 incautiously shot himself in the region of the liver. The ball of seven mms. entered immediately under the arch of the ribs, the weapon being held perpendicularly. Two hours after the accident his pulse was accelerated, his hepatic region painful, and his appearance pale. A perforation of the liver was diagnosed and he was treated expectantly. He was carefully observed. His pulse was normal on the second day; icterus appeared then and disappeared on the third day. An uneventful recovery followed.

3. A boy of 13 was shot by a bullet from a revolver, the projectile piercing the chest in the right mammary line, right under the right costal arch. Under anæsthesia neither a bullet nor a canal entering the abdomen could be detected. It was assumed that the ball had glanced from the rib. He was soon discharged cured. In sixteen days after he became decidedly collapsed, with high fever and violent vomiting. The threatening symptoms soon ceased and a hectic state, with great emaciation and enormous swelling of the liver and spleen, followed.

The right lobe of the liver reached nearly to the right anterior iliac spine. The evacuations were constipated and clayey at times. Repeated trial punctures yielded nothing but blood; as no pus was detected no operation was done. In six weeks there was a gradual fall in the fever, a retrogression of the swelling of the liver, an improvement of his general condition, and finally a recovery. Probably a large hæmatoma had formed between the liver and diaphragm.—*Berliner Klinische Wochenschrift*, No. 33, 1898.

FRANK H. PRITCHARD, M.D.

VOMITING IN PREGNANCY A NEUROSIS.—Dr. Klein, of Munich, confirms Prof. Kaltenbach's view that the hyperemesis gravidarum is a neurosis, either of hysteric or neurasthenic origin. He advises the same treatment: rest in bed, fluid foods, and, if these fail, transference to an institution.—*Ibidem*, No. 32, 1898.

BACTERIA OF THE VAGINAL SECRETION OF THE PREGNANT WOMAN.—Williams has repeated his examinations of the vaginal secretion in pregnancy, as opinions of observers differed. He has examined 25 new cases in addition to the 92 reported six months ago, making a total of 117 cases in which the vaginal secretion was obtained by means of Menge's tube, and in which streptococci were not found at all, and staphylococci only in 2 cases. His conclusions on the 25 cases examined are:

1. This work tends to reconcile the conflicting results of the various observers by showing that they are due to the difference in the technique by which the secretion was obtained for examination, and not to gross errors in bacteriological work.

Those who obtained the secretion by means of a speculum carried bacteria from the vulva up with it, and necessarily got positive results; while those who obtained their secretion by means of a small tube avoided so doing, and obtained negative results.

2. This series of cases serves to confirm the previous work of Krönig and myself, which conclusively shows that the various pyogenic bacteria which give rise to puerperal infection are not found in the vaginal secretion of pregnant women.

3. This being the case, autoinfection with these organisms cannot occur, and when they are found in the puerperal uterus they have been introduced from without. Accordingly, prophylactic vaginal douches are not necessary, and are probably harmful, laboratory work thus standing in direct accord with the practical experience of most clinicians.

4. The work clearly demonstrates the danger of vaginal examinations, as I have shown that the introduction of a small cylindrical speculum, which is certainly no larger than two fingers, carries up into the vagina, in 50 per cent. of the cases, whatever pathogenic organisms may be present at the vaginal entrance.

In view of the extreme sensibility of the vulva, and the manifest impossibility of disinfecting it with anything like the certainty with which we can disinfect our hands, it becomes apparent that the introduction of a perfectly sterile finger into the vagina is not always a harmless procedure.

5. The danger of the vaginal examination being thus demonstrated, it is apparent that it must give place more and more to the external examination of the pregnant and parturient woman.—*American Journ. of Obst.*

TECHNIQUE AND USE OF SALINE INFUSIONS (Reilly).—The saline solution can be made for ordinary purposes by two teaspoonfuls of salt (small teaspoonfuls brushed off with a straightedge) added to a quart of water, and the solution is then boiled and filtered. The temperature of the solution when given should be 115° to 120° F. (Dawbarn). Its indications are:

1. In all cases of severe hæmorrhage, whether external or internal.
2. In shock, both simple and post-operative, it fulfils all indications.
3. In all toxæmic conditions, and here it should follow venesection. In-

deed, no agent thus far compares with it in efficacy in uræmic and septic conditions.

4. In cases of poisoning due to vegetable or mineral substances.

5. In any pathological state attended with feeble pulse, due to diminished arterial pressure.

6. As a last resort in cases of imminent death from any cause of an accidental nature.

GEORGE R. SOUTHWICK, M.D.

DIAGNOSIS OF TUBAL PREGNANCY.—Dr. Fritz Frank, of Cologne, warns against being too ready with a diagnosis of tubal pregnancy. He dwells emphatically upon the tendency of gonorrhœal disease of the appendages to bring about a clinical picture where everything seems to point to a certain diagnosis: Swelling of the breasts, colostrum in the breasts, temporary absence of the periods, with subsequent hæmorrhages from the uterus, general symptoms, nausea, vomiting, enlargement of the uterus, a pallid appearance, etc. He mentioned cases which he had treated together with physicians in Cologne, and one which had deceived him, which, on operating, was found to be a pyosalpingeal sac that had already burst. Also small cysts of the parovarium may easily simulate when the other symptoms fail. Only an inexperienced physician will laugh when it is stated that the retroflected pregnant uterus is readily taken for a tubal pregnancy. Especially if gynæcological treatment has been continued for years, the cervix may be so hard and firm that that part of the uterus alone is regarded as the whole organ, and the softened fundus, fallen into the cul-de-sac of Douglas, is looked upon as a tumor. A tumor developing alongside of the uterus with absence of the periods may mislead one; on the contrary, the persistence of the menses may lull one into a false security. He advises in doubtful cases to give the patient the benefit of the doubt, to put her to bed, and to keep her under observation. Curetting is of valuable service in doubtful cases and devoid of danger. Veit's words, that "tubal pregnancy is to be regarded as a malignant growth," is a little too emphatic to-day. If the decidua is passed off then the foetus has died, and one may wait. Yet then the patient must be kept in bed and watched carefully. A recovery is most frequent then. Electricity or morphine as measures to kill the foetus is dangerous and uncertain. In this stage the sac is adherent and operation dangerous. If it be thin-walled, movable and free, then immediate operation is indicated. With a ruptured sac and free bleeding, incise rapidly, seize the uterus and draw it forward, grasp the sac and ligate it off, removing the coagula. If encapsulation has occurred, as shown by dulness, then expectant treatment with absolute rest. In hæmatocele do not wait too long before operating. The operation may be advantageously done from the vagina if it be large and relaxed. Pains in the pit of the stomach are indicative of beginning tubal pregnancy. Ice applied to the abdomen has caused free hæmorrhage to cease for a time.—*Muenchener Medizinische Wochenschrift*, No. 33, 1898.

TREATMENT OF THREATENING ECLAMPSIA.—Dr. P. Drejer is an advocate of treatment by milk diet in menacing eclampsia as recommended by Professor Tarnier, stating that it must be employed "avec une rigueur inexorable." Absolute rest in bed, disregard of which is liable to be followed by a reappearance of the albuminuria, and the use of milk for at least fifteen days,

after which the usual diet may be gradually resumed. The patient should not get up until she feels that she can easily tolerate it. Milk increases the flow of urine, and causes the œdema to disappear. Diuretics are superfluous (and dangerous); drugs are of secondary importance. In case of agitation and anxiety, associated with headache, one may employ moderate doses of chloral, with satisfactory results. In the majority of cases the writer has found this method to be successful and the renal complications to disappear without returning. If this result be not obtained in fifteen days then he advises producing abortion, that the eclamptic toxins be not given an opportunity to bring about definite renal lesions. This measure may also save the life of the fœtus, for if left to itself the child is prone to die and to be expelled macerated. As auxiliary measures he recommends injections of salt water and venæsection.—*Norsk Magazin for Lægevidenskaben*, No. 8, 1898. —Dr. J. Gordon, *Lancet*, January 15, 1898, and *Wiener Medizinische Presse*, No. 33, 1898, speaks warmly in favor of the use of veratrum viride in puerperal eclampsia. In a case he gave, according to Stephanson's directions, five drops of the fluid extract and obtained a rapid and persistent effect. The arterial tension quickly decreased; in fifteen minutes the pulse sank from ninety-two to a hundred down to fifty-two in a minute, and continued at fifty-four to sixty for hours, when the attacks ceased. Even after ten hours the arterial tension was reduced, the pulse soft, full and easily compressible. The remedy also brought about a rapid dilatation of the external os. Disagreeable after-effects were nausea, vomiting and profuse salivation. Veratrum viride contains two alkaloids: jervin reduces the force of the heart-beat by direct action on the myocardium, and brings about general vaso-motor paralysis. The other, veratroidin, irritates the inhibitory cardiac nerves, decreases the frequency and acts on the motor centers of the cord. Therefore the value of the remedy in eclampsia.

FRANK H. PRITCHARD, M.D.

A CASE OF EPITHELIOMA OF THE MIDDLE EAR.—Although only twenty such cases are to be found recorded in literature, the writer has met with three. In the case which he reports the growth first appeared as a polypus, which was removed.

The recurrence was very rapid, appearing as a purple, slightly mammillated, friable mass filling the concha, which microscopical examination proved to be epithelioma. The patient died in six months.—G. C. WILKIN, *Journal of Laryngology, Rhinology and Otology*.

ACNE ROSACEA AND ITS TREATMENT.—After correcting intranasal pathologic conditions, such as hypertrophy, septal obstruction, etc., the acne of the nose was treated in the following manner: Infiltration anæsthesia was first established, and the patient ordered to drink a couple of glasses of wine, in order to develop the efflorescence of the nose more markedly. The fine point of a cherry-red cautery-needle was passed over the vessels, occasionally pressing a little deeply. After the operation ice-compresses were applied for some hours and rest in bed ordered. Later, sedative dressings were used. The reaction was extremely slight. Repeated applications were made to the dilated capillary vessels and to the nodule until the whole nose had been treated. A month later the patient appeared cured and the scar was almost

invisible.—F. BLOEBAUM, *Deutsche Med. Zeitung*; *New Orleans Med. and Surg. Journal*.

FALLACIES IN THE PHYSIOLOGY AND FUNCTIONS OF THE LABYRINTH.—The writer combats the present accepted theories concerning the function of the semicircular canals by reference to a case of extensive exfoliation of the labyrinth. This patient walked into the assembly hall of the medical society with a thoroughly steady gait and a perfect sense of direction, walking with head and body erect, and turning to the right or left as indicated by the members of the society conducting the examination; and all the while the exfoliated labyrinth, containing the cochlea and semicircular canals taken from the right temporal bone, was lying upon the table. It was even possible to demonstrate that there was still some hearing power remaining in the affected ear.—M. A. GOLDSTEIN, *Laryngoscope*.

ANGIONEUROTIC EDEMA OF THE TONGUE.—The patient, a school teacher of 27 years, had been suffering from simple neurasthenia. After eating some ice cream and macaroon cake her tongue began to swell, and soon almost filled the mouth. Cough and dyspnoea developed, and the left side of the neck showed marked external congestion. The left side of the nose began to swell, and respiration became so difficult that there was fear of suffocation. One-half hour later the symptoms began to subside, and an hour afterwards all signs of the angineurosis had disappeared. The attack occurred on the day on which the menstrual function was due.—F. K. HALLOCK, *Atlantic Med. Weekly*.

INDICATIONS FOR INTUBATION.—The majority of cases recognized early are amenable to treatment by antitoxin. A certain number, however, fail to respond to the remedy. In these cases, if after the end of twenty-four hours a study of the symptoms leads to the conclusion that the patient is not better, then intubation should be done. In all cases presenting any of the following symptoms prominently, viz.: Deep epigastric recession with each inspiration, labored and prolonged expiration, extreme restlessness, spasmodic attacks coming on at intervals, or persistent cyanosis, then intubation should be performed.

In cases seen late, it would be wise to intubate and administer antitoxin rather than to give the remedy and wait for its effect.—H. M. McCLANAHAN, *Jour. Amer. Med. Assn.*

DEATH-RATE IN DIPHTHERIA.—The author denounces antitoxin, stating that the published percentages are misleading, and that the actual mortality from diphtheria has not diminished in late years, as claimed. He cites statistics from Moscow, London, New York, etc., which prove that the number of deaths has not decreased, whatever the percentages may show, while statistics everywhere prove that tracheotomy, primary or secondary (after intubation), is still followed by death in 70 to 90 per cent.; that the number of cases of consecutive paralysis has actually increased, and that renal complications are not affected by the antitoxin, while croup continues its course unchecked by the injections. In the cities (Vienna and Paris) in which the mortality is actually lower in recent years, the disease has been of a milder type.—KAS-SOWITZ, *Jour. Amer. Med. Assn.*

WILLIAM SPENCER, M.D.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND
THERAPEUTICS.

MEDICINES OF USE IN ULCERATIVE ENDOCARDITIS.—Dr. Byres Moir, of London, discusses septicæmia and the essentially septic nature of infectious or ulcerative endocarditis, several cases of which he records at some length. Regarding treatment, he recalls that when first he began studying these cases he had a good many in the hospital, and he wrote to Dr. Hughes to ask what he considered the best remedies for this state. The latter suggested aconite, the ordinary mother tincture, or the arseniate of quinine, and Dr. Moir gave them a fair trial in many cases. Aconite certainly has many of the symptoms; even in the provings it produced vegetations on the valves of animals where it was given, but Dr. Moir considers that it will meet only a simple, or somewhat simple, endocarditis, and not a true infective one. In only one case that was of the infective form did it seem of much use; the patient went out apparently cured, and died a year or two afterwards from a second attack. At the *post mortem*, on the wall of the left auricle there was a large scar that looked like the result of the old ulceration which had healed over. He tried aconite in many other cases, but has seen no results since; and from the arseniate of quinine he has derived no benefit at all.

Of late years the anti-toxins have been largely tried. The anti-streptococcic serum has certainly answered in puerperal conditions, but it has failed in most of the cases of infective endocarditis. One or two cases have been reported as cured, but it is quite exceptional to get any improvement with it. In one case mentioned by the writer five or six injections of anti-streptococcic serum were given, but it had not the slightest effect on the temperature or the general condition. Another remedy much used in America in all septic conditions is nuclein or nucleinic acid. In this form it is prepared from a sterilized yeast extract, and the view taken is that it increases the natural resistance to disease by giving the blood a germicidal element, corresponding to the nuclein of the white corpuseles. Its power to produce leucocytosis has been proven by experiment. Nuclein contains a high percentage of phosphorus. In one case mentioned nuclein was used hypodermically, and the temperature fell while it was being used, but the case had gone on too long to expect anything but a fatal issue. With regard to leucocytosis, it certainly would be a favorable condition if the cells attack and overcome the germs in the blood.

The other medicines to which Dr. Moir has turned of late have been the snake-poisons, and there we have more hope than elsewhere. With regard to the use of lachesis in septic conditions, we now know the use of it in poisoned wounds and in infections spreading by the lymphatics. In these cases he has over and over again convinced himself of the value of lachesis. Crotalus is an-

other medicine that he has seen used in septic conditions. In two cases that got better, the medicines which did most good were naja and strophanthus. One has been taking naja some time and seems to do well under it.—*Journal of the Brit. Hom. Society.*

THE REMEDIES FOR FLATULENCE.—According to Stonham, of London, there are a great number of remedies useful for flatulence, but six stand out pre-eminently, viz. : carbo veg., bryonia, lycopodium, china, argentum nit., and nux vomica. It will be useful to differentiate a little between them.

With *carbo vegetabilis* there is much distention and full feeling, so much so that the stomach feels very heavy and as if hanging down, and the abdomen full and bursting. The flatulence seems equally distributed to stomach and bowels, and large quantities of flatus are passed both upwards and downwards without effort and without relief—the flatulence does not by its presence excite painful spasmodic action in the gastro-intestinal muscular walls.

With *china* the bloated, distended feeling of the stomach is accompanied by eructations which are bitter, or taste of food, and by belching, which does not relieve; and there are spasmodic constrictive pains in the abdomen. The bloated feeling is relieved by motion (the reverse of bryonia). China is especially useful in cases caused by excessive tea-drinking or by depletion of the system, and the spasmodic pains are usually worse at night. It seems to be more related to an exhausted nervous system than the other flatulent remedies.

With *argentum nitricum* the flatulence is mainly confined to the stomach; there is belching after every meal, but it occurs with difficulty, as though there were a resistance to be overcome at the cardiac orifice, which is finally overpowered with the discharge of flatus in large volumes and with great violence.

With *bryonia* there is much distention and great sensitiveness of the abdomen, confined mostly to the upper part; there are stitches and other pains, which hinder respiration: the symptoms are worse from any movement, however slight; hiccough and eructations come on immediately after food; the eructations relieve.

With *lycopodium* there is not much flatulence in the stomach, but a great deal in the intestines, especially in the colon. It becomes incarcerated, and causes pressure upwards on the diaphragm, with a sensation as if a cord were tied around the waist, and downwards on the rectum and bladder. There is much rumbling of wind in the splenic flexure of the colon, and great fermentation in the abdomen, with rumbling and croaking, colic, and a discharge of quantities of flatus per anum. It is, on the whole, our most useful remedy for intestinal flatulence.

With *nux vomica* the epigastrium becomes bloated, but not till two or three hours after a meal, and there is a pressure as of a stone there; there is also some pressure under the short ribs. There may be a good deal of spasmodic colic and pressure downwards, and ineffectual urging to stool. There is more colic and less distention than in lycopodium, which it most closely resembles.—*Journal of Brit. Hom. Society.*

HEROIN, A NEW MORPHINE SALT.—Heroin is a new salt of morphine which will be of great service in therapeutics, according to the opinion of M. Floret, who has experimented with it in sixty cases. It is very useful in controlling cough, from whatever cause; it has been tried in twenty-five cases of

confirmed tubercle, with complete success in twenty-one. The same results obtained in coughs from acute or chronic bronchitis, pharyngitis, laryngo-tracheitis and asthma. The dose is from 5 milligr. to 1 or 2 centigr., repeated three or four times daily, according to the gravity of the case and the age of the patient. It is well tolerated by the digestive organs, with no vomiting, constipation or other ill effects. In the sixty patients who used heroin only one complained of slight vertigo.—*N. Y. Med. Times*, Jan., 1899.

IODIDE OF LIME IN CROUP.—Before the Academy of the Chicago Homœopathic Medical College Dr A. G. Beebe narrated his experience with the iodide of lime in croup. His own use of the drug for at least twenty-five years has been in cases of the latter, although he presumes that it might be of service in other coughs. It is an unstable remedy, and must be prepared fresh for every case. Triturations of an impure calcium iodide have been prepared. The proper chemical is a dark-brown crystal, made by saturating the lime with the iodine, and is called Nichols' iodide of lime.

The speaker had used the drug in all cases of croup (not diphtheritic) for more than twenty years, and in that time had never lost a case. He gives it in doses of from one-fourth to one-half grain of the crude drug, repeating at intervals of an hour, or, if the symptoms are urgent, as often as every fifteen to thirty minutes for the first few doses. It should be continued until the dry, croupy cough gives place to a moist or catarrhal one, and until all danger of recurrence during the night has passed. After that, other suitable remedies may be used. It may be given mixed (not triturated) with sugar of milk, so as to make a convenient-sized dose, or it may be put into water; but as it is very unstable, it should be exposed to light and air as little as possible. He does not know whether it can be considered homœopathic or not; certainly iodine is homœopathic to laryngeal cough.—*Med. Era*, January, 1899.

F. MORTIMER LAWRENCE, M.D.

FERRUM IN ANÆMIA, CHLOROSIS, ETC.—Iron is and always will be the chief remedy in anæmia, and particularly in chlorosis, according to Dr. Leopold Grossberger, of Bromberg, Germany, for it will do what puls. and cal. carb. will not. Not in massive doses, "viel hilft viel," but in the first or the second decimal trituration, a few grains two or three times a day. The German homœopaths prefer the carbonate ferrum carbonicum. In chlorosis it is only of service where it has not been abused in large doses, and where there are no stomach pains. In the former case he advises cupr. acet. 4x twice a day; then follow with small doses of iron. (Prof. Kobert states that in some animals copper replaces iron in the blood-corpuscles, their blood having naturally a greenish-red appearance.) In persistent hæmorrhages from the lungs and uterus, even without a chlorotic base, it is an excellent remedy; it may be intercalated. All the fresh air possible, both by day and night, should be obtained—in the summer, several hours in the open air, and in the forest, if possible; and in both seasons sleeping with the window of the bed-room somewhat open, but not too near the bed, if it be not too cold or stormy. Each day at least one quart of milk should be sipped in small quantities. Forbidden articles of diet are coffee, tea, pungent spices, alcoholic drinks, sausage and pork, including ham, salted and smoked pork, old cheese and herring. Corsets and garters should be discarded. Three to four times a week a sitz-bath should be taken of 22° Reamur, of fifteen minutes' duration,

after which one should go to bed and get warm, or, if the weather be favorable, walk about.

He records a case of a young lady who from her fourteenth year had suffered from chlorosis, being weakly and sickly, and whose case had been diagnosed as hypertrophy of left ventricle by three Viennese professors. She suffered at times from seizures of vertigo with confusion of head, periodic roaring in the ears, varying in intensity, throbbing, especially in the left, her face pale, her look dull; at the slightest exertion her face would flush up, her lips become pale, with frequent trembling of her lower lip, visible pulsation of the carotids, *dyspnœa with restlessness and anxiety*, especially on movement, frequent and slight coughing without expectoration. Her heart-beat was accelerated and heaving, externally visible and increased even by turning over in bed, etc. She had been treated in every manner, both allopathically and homœopathically. Ferrum carb., 2x, was given twice a day. In four weeks there was a "*visible improvement*," and with a long-continued use of iron she became entirely well. It is doubtful whether an organic heart lesion existed.—*Leipziger Populäre Zeitschrift fuer Homœopathie*, Nos. 19 and 20, 1898. (It is nowadays recognized that chlorosis may be accompanied by a dilated heart.—F. H. P.)

PERNICIOUS FORMS OF MALARIA AND THEIR TREATMENT.—Dr. Leon Simon, of Paris, in a recent article discussed the treatment of pernicious varieties of malaria. Here frequently, as the first even may be fatal, one should not hesitate to give vast doses of the only certain drug, quinine. He recommends a mixture of equal quantities of the sulphate and milk sugar, triturated for half an hour. Of this administer seven or eight grains every half-hour until a reaction sets in. One may increase to three or four grams. of the mixture. Or, if the stomach reject it, then administer it hypodermically. (In such a case it would be folly to wait for a few grains to be absorbed by the stomach. Inject fifteen to thirty grains at once under the skin, in an appropriate mixture, as that used in the Clinica di Roma, Italy; muriate of quinine, salt, 0.75, and distilled water, 10.0. Apply a bandage to the arm above the elbow to cause the veins to swell out, and introduce the needle into a vein. Inject slowly and take off the bandage. If an elevation follow it has been injected under the skin only and not intravenously, as should be done. In the pernicious forms, and particularly the comatose, one cannot afford to dally with small doses and be sorry afterwards.)

The patient should be under surveillance for fifteen days to three weeks to avoid recurrences.

If the fever be remittent or subcontinuous, then ars. in the periods of remission should be administered every two hours. If this does not control the next attack, then *do not* throw aside the quinine but choose a drug according to the indicative symptoms of the attack, and alternate it with it, giving the former in the apyrexia. The following are summary indications:

Apoplectic Form.—*Arnica* if the pulse be full, hard, with paralysis of one side, loss of consciousness and extravasation of blood beneath the conjunctivæ and the skin. *Belladonna* if the face be red, congested, the pupils dilated, and if there be retention or incontinence of urine. *Opium* if there be apoplectic sleep with a rattling respiration or stertor, with contracted pupils. *Agaricus* in similar condition with aphasia.

Comatose Form.—*Opium*, with the enumerated symptoms and constipation. *Stramonium* in comatose sleep in which the patient has convulsive attacks in his limbs.

Ataxic Form.—*Bell.*, *hyosc.* and *stram.* when the cerebral symptoms predominate. *Nux vom.* and *phos.* when the spinal cord is affected and there is a paralysis of the lower limbs. *Nux* is particularly of value in constipation and flaccidity of the rectum. *Phos.* in diarrhœa and sense of suffocation.—*Revue Homœopathique Française*, No. 8, 1898.

TREATMENT OF HÆMATURIA OF VESICAL ORIGIN.—Dr. R. Staeger advises, in this variety of hæmorrhage from the urinary passages, the following remedies:

Mezereum.—Recommended by Dr. Hirschel in hæmorrhoids of the bladder and hæmaturia resulting therefrom.

Uva uris.—This drug or arbutin is of service in catarrhs of the bladder, and stanches hæmaturia when chronic catarrh forms ulcers in the mucous membrane of the bladder.

Lycopodium.—This remedy may be employed where there is a stone in the bladder or if it be surmised, and, in general, in the uric acid diathesis. Also in chronic catarrhs of the bladder, with retention of urine. In this respect sarsaparilla acts similarly to lycopodium; benzoic acid is another analogous remedy.

Copaiva.—This drug also causes catarrh of the urinary passages, with burning and urging to urinate in the neck of the bladder and in the urethra. *Copaiva* and *cubeb*s are useful in irritation of the mucous membrane of the bladder in consequence of a stone or in a thickened mucous membrane from chronic catarrh. Bloody urine.

Erigeron.—Bloody urine is also under the control of this remedy.

Camphora.—This drug, like *cantharis*, causes delirium, convulsions, priapism, strangury; useful in catarrh of the bladder.

Cantharis.—This drug is here the chief remedy, and it acts excellently in severe inflammation of the bladder, in irritation of the bladder from stones, etc. There is great hæmorrhage where the urine is passed frequently and in dribblets, with frequent urging. The urine is of a bright and bloody-red color. The symptoms reach the highest degree, and above all the pain predominates.

Capsicum.—Indicated in affections of the bladder in persons who are obese, slothful and of a lymphatic temperament.

Thuja.—Very valuable in bladder affections when there is continual tenesmus of the bladder, and where, on attempting to urinate, only a few drops of bloody urine are passed.

Belladonna.—Acts excellently in the beginning of vesical diseases.

Cannabis.—Similar to *cantharis*. It is employed in catarrhs and in cases of stone in the bladder. *Hyosc.* and *opium* quite similarly to *cannabis*.—*Tratch Gomeopat*, No. 6, 1898.

SYNCPAL FORM OF MALARIA.—This variety, one of the most grave, requires most decidedly the use of quinine. As soon as danger has passed one may use *carbo veg.*, *lachesis*, *arsen.* and *aconit. φ.*—*Revue Homœopathique Française*, No. 8, 1898.

FRANK H. PRITCHARD, M.D.

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SUMMA SUMMARUM ALTERNATIONIS?

BY R. B. LEACH, M.D., ST. PAUL, MINN.

IN "The Science of Therapeutics" (page 162) Carrol Dunham says: "But alternation is nowhere advised or allowed."

IN "The Life and Letters of Hahnemann" (page 480) Bradford says: "Hahnemann in no manner sanctioned alternation after this time" (1833).

IN "The American Homœopathist," July, 1895, Frank Kraft says: "Hahnemann did not countenance alternation. He could not. The logic of his whole system of medicine would confute him at every point. It grew out of a mis-translation of *The Organon*."

As I recall my childhood I remember few things more provoking to me at that time than to have a child, who differed with me and who evidently could not or would not prove his point, stick his tongue out and say "he didn't," "he didn't," "he didn't." How much more provoking in manhood, and seeking more light, to have those who "might, should, could, or would" impart it, answer: "He did not;" "He could not;" "He nowhere advised or allowed;" "He in no manner sanctioned it;" and not one of these ever tried to PROVE the belief that is in him.

There was a time when, from accepting as the gospel a literal

translation of Hahnemann's writings, I endorsed the right of others to alternate two remedies (if they saw fit) because, as I then thought, Hahnemann had so taught; and I occasionally practiced the same; but I am prepared, now, to endorse the asseverations of those opposed to this practice because, more especially, "the logic of his whole system of medicine would confute him at every point."

This conclusion has been slow in materializing, though hovering always nearer and nearer, and is now made public for the first time (and now only after a fruitless search for proofs of others' beliefs), and I now most respectfully submit the reasons for my belief in the use of the single remedy, and trust the effort may not be wholly without influence upon many a wavering frater who feels it is illogical to alternate, who will not alternate, because his experience is against it, yet who has never taken the trouble to obtain positive proof that the founder of Homœopathy did not alternate remedies though quoted as having done so.

Not having access to all productions from the masterly pen of this inimitable scholar, I hesitate to even insinuate that Hahnemann ever, even before 1833, advised or allowed alternation (as we at this time understand this word and method of practice), and in the following pages I feel I shall show wherein all of his translators have misinterpreted his *intent*, and have, consequently, given us the *literal* translation of his active verb, "abwechseln," "to alternate," and its modifications, and have *not* given us their several *equivalents*; and in this *dissertatio in retro-spicio* I sincerely beg your indulgence and most earnest consideration.

For instance, in the "Life and Letters of Hahnemann" (page 148) we find the statement, "I would advise you to take a small globule, charged with the tincture of sulphur (*Spiritus Vini Sulphuratus*) and allow it to act for at least thirty days. This to be followed by the alternate use of phosphorus 1x and sepia 1x, *whichever* is most useful to be taken first; which is the best method for such a psoric cough."*

All students of the English, and I presume of the German also, recognize that the relative pronoun "*whichever*" (in the

* The italics are mine.—R. B. L.

above quotation) designates an *alternative* between the two remedies phosphorus and sepia, and that the adverb, alternate, which here modifies and shows the action of the transitive verb "used," could not be a verb and an adverb simultaneously; consequently the English version could have been rendered more intelligible had the English *equivalent* for the German adverb, abwechselnd, been used instead of the *literal* rendering of the German verb, abwechseln, "to alternate," for Hahnemann's injunction very plainly implies a choice of the two, or the *alternative* between the two, and *not* the alternating or rotating of the two remedies mentioned.

Again, on page 272 of this same book we find this same verb, "to alternate," used by the translator where it is now incomprehensible to us how Hahnemann (who says, "for Lehmstadt I advise to alternate with platina, hepar and toxicodendron; leaving each medicine to act fourteen days") could have intended or enjoined a rotation or alternation of these different remedies (*i.e.*, the alternating one with two others together, viz., the conjunction, AND, implying conjoint action) and yet specify that *each* shall be left to act fourteen days.

But, to the contrary, it is comprehensible that, with his extended knowledge of German, recognizing that "to alternate with" and "the alternate use of" are synonymous in intent, he meant the alternate use of platina, hepar and toxicodendron; which interpretation would, translated into the English *equivalent*, imply the *alternative* BETWEEN the three to begin with; and then the *alternative* of following with either of the others, "*whichever*" might or might not then be indicated; the three being especially mentioned in this instance because his experience had taught him that these three were, more often than other remedies, indicated under the conditions described as then obtaining in his friend Lehmstadt.

If the practice of alternation, therefore, grew out of a mistranslation of the *Organon*, as Dr. Kraft averred, then indeed it behooves the several translators of that most classic composition to repair their mistakes; and, that at least a defence of their works may be presented, I most sincerely trust they may see this paper and endorse or correct the deductions made above as well as those which follow, and thus exonerate their endeavors.

If, as my dictionaries define it, "a translation of a writing implies and enjoins the expressing of the *sense* of words in one language by *equivalent* words in another," then surely a rendering or interpretation of the sense or expressions in one language which does *not* render such into an *equivalent* in another, but only renders the word or expression of the one into a *literal* word or expression of the other, *which same implies in the other an entirely different meaning* (in fact its antonym), then indeed is such rendition of the original a mis-translation, and, in such an important subject, worthy of reconsideration and reproduction.

If, therefore, Drs. Dudgeon and Wesselhoft have mis-translated Hahnemann's *Organon*, their respective renditions of this masterpiece, when duly analyzed, will refute any asseverations to the contrary, while, if these gentlemen have given us the English *equivalent* for the German text, their several editions of these laws of Homœopathy stand as even more glorious monuments to their efforts; and of such analysis I now most respectfully ask their consideration, as well as the attention of all contemporary students of Hahnemann's several publications wherein he makes use of the verb "abwechseln," and its modifications, as they have been interpreted for us.

Wesselhoft's translation of paragraph 232 of the *Organon* (5th edition, 1875) reads thus: "The order of alternating diseases is also of great variety, but all belong to the class of chronic diseases which are mostly a product of developed psora. In some rare instances they are complicated with syphilitic miasm. In the first instance they are cured by psoric medicine, but in the latter case the treatment should be conducted by *alternating* antipsorics with antisiphilitics *according to the instructions contained in the book on chronic diseases.*"*

Dudgeon's translation (1896) of this same paragraph reads thus: "These latter, *alternating* diseases, are also very numerous, but all belong to the class of chronic diseases. They are generally a manifestation of developed psora alone, sometimes, but seldom, complicated with a syphilitic miasm, and, therefore, in the former case may be cured by antipsoric medicine; in the latter, however, *in alternation with* antisiphilitics, *as taught in my work on the chronic diseases.*"*

* The italics are mine.—R. B. L.

Now, the first noticeable intent displayed by these translators is the unanimity with which they endeavor, although differing in their syntax, to express in English *equivalents* their concurring interpretations of Hahnemann's meaning; for, while we find the one using the phrase "very numerous," the other expresses the same meaning in the synonymous phrase, "great variety," and while the one uses the expression "in some rare instances," the other uses the equivalent expression "sometimes, but seldom;" and Dr. Wesselhoeft, using the present participle, "by alternating," tells us only what Dr. Dudgeon tells us with his substantive, "in alternation with."

Second, we infer from the above that each meant the same thing when the one used the participle and the other the substantive for the verb "abwechseln," "to alternate," for if both or either meant to convey to us anything else than the *literal* meaning of this verb, then would both or either have first interpreted Hahnemann's word differently, and would subsequently have translated the same into its English equivalent.

That each used English *equivalents* freely for all other words and terms, but that neither used an *equivalent*, but did use the *literal* translation, for this particular verb and its parts (*i. e.*, "by alternating," or "in alternation with") leads to one conclusion, *viz.*, each meant to convey to his English readers that the correct interpretation of "abwechseln," "abwechselnd" and "abwechselung" is, as stated in their translation, "the alternate use of" or "the alternation of," or rotation of two different medicines, matters or forces; or the reciprocal succession of same in time or place, as "the alternation of day and night, cold and heat, summer and winter."

Now, if one is right in his interpretation and translation the other is also right, while if one is wrong the other is equally wrong, and it devolves upon both to correct their mistakes; and if they are right, "*the instructions in the book on chronic diseases*"* will bear them out, while, if they are wrong, these same instructions, which modify, qualify or intensify the implications contained in this paragraph, will confute their translation and prove it irrefutably the "mis-translation" it was averred by Dr. Kraft to be.

* The italics are mine.—R. B. L.

"The instructions in the chronic diseases," pages 84 and 85, read thus: "The gonorrhœa dependent on the figwart miasma, as well as the above mentioned excrescences (*i. e.*, the whole sycosis), are cured most surely and most thoroughly through the internal use of thuja, which, in this case, is homœopathic in a dose of a few pellets as large as poppy seeds, moistened with a dilution potentized to the decillionth degree; and if further doses of thuja are required, they are used most efficiently from other potencies, and, when they have exhausted their action, after fifteen, twenty, thirty or forty days, *alternating* with just as small a dose of nitric acid, diluted to the decillionth degree, which must be allowed to act as long a time in order to remove the gonorrhœa and the excrescences, *i. e.*, the whole sycosis. But if the patient was at the same time affected with another chronic ailment, as is usual after the violent treatment of figwarts by allopathic physicians, then we often find *developed* psora complicated with sycosis when the psora, as is often the case, was *latent* before in the patient. At times, when a badly treated case of venereal chancre disease had preceded both, the miasmata are conjoined in a threefold complication with syphilis. Then it is necessary *first* to come to the assistance of the most afflicted parts, the psora, with the specific antipsoric remedy (given below), and *then* to make use of the remedy for sycosis *before* the proper dose of the best preparation of mercury (as will be described below) is given against the syphilis. The same *alternating* treatment may be continued until a complete cure is effected. ONLY, each one of these three kinds of medicine must be given the proper time to complete each action."*

This quotation (the translation of Hughes and Tafel) but adds to our list of Hahnemann's interpreters who are either right or wrong, as are the others, in their production; therefore the above, and all subsequent conclusions, are most respectfully submitted for the approbation or condemnation of these gentlemen also; and, to proceed, while it is true that others rendered into English "the instructions contained in the chronic diseases," it is equally true that *all* agreed upon the interpretation of the intent conveyed by them in the words

* The Italics are mine.—R. B. L.

“to alternate,” “altern’ate,” “alterna’tion,” and “altern’ating,” for each has used the *equivalent* of the German sense for the *alternating* action or performance, as “the alternation of day and night, heat and cold, summer and winter,” implying unanimity in the belief upon their part; and this is *not* the *equivalent* necessary to correctly convey in English Hahnemann’s *intent*.

Removing this avenue for further difference between us, I will now endeavor to substantiate my right of concurrence with Dr. Kraft against the translators, and in this respectfully call attention to the statement of Hahnemann that the psora, *before* latent, we often find *developed* when complicated with sycosis, and that THEN it is necessary to FIRST cure the psora with the antipsorics, and THEN to cure the sycosis BEFORE the syphilis is attacked with the antisiphilitics; therein specifying (*i. e.*, allowing of no *alternative*) the attention to three different pathologic conditions, *each in its turn*, and exhibiting against each its specific curative, not altern’ately, nor in alterna’tion, nor in an al’ternating manner, but in a regular series of succession or descending scale from the severest to the least harmful condition; and that, in case the patient still presents symptoms of some one or the other remaining specific similimums (*i. e.*, is not cured), and it be deemed expedient, “the same alternating treatment (*i. e.*, this same succession of remedials) may be continued until a complete cure is effected;” but this implies reconsideration, a *new* prescription, and thus eliminates alternation; while, in reference to the alternating of thuja and nitric acid (the alternative of using either thuja or nitric acid being removed by the conjunction AND), the same reasoning obtains for deciding against the *literal* and using only the *equivalent* translation for the present participle—abwechselnd, “alternating.”

Such translations can signify but one of two mental conditions upon the part of all of these gentlemen, viz., either that they *all* failed to appreciate or interpret his *intent*, or that none could express in the English an equivalent for that intent; and, the latter supposition being absurd upon its face, there remains but the possibility that, deciding in their minds that because Hahnemann justifies, “in the most acute diseases,” the frequent repetition of the indicated remedy, even to every five minutes (*Organon*, Chap. 247), and because he says (referring to Asiatic

cholera, one of the most acute diseases): "Sometimes, when aid is delayed many hours, or other and improper remedies have been administered, the patient falls into a sort of typhoid state, with delirium. In this case, bryonia x, alternately with rhus tox. x, proves of eminent service" ("Lesser Writings," p. 755, by Marcy and Dudgeon); and, because of this *apparent* concurrence, he means the *literal alternation* of bryonia and rhus just as "the alternation of day and night," when the probability is that the adverb "altern'ately," the substantive "altern'ative" and the participle "alternating" being, each and every one, expressed in the German text by the single word "abwechselnd," he meant here, as elsewhere, the succession of bryonia *by* rhus tox., since the conjunction, "with," eliminates any intention of an alternative between bryonia *and* rhus, and since the reasons stated above obtain equally in this instance against a *literal* translation.

Again, in the "Lesser Writings" (p. 756), wherein he is referring to cuprum, he is made to say: "The best homœopathic practitioners have also found *it* indispensable in the second stage of the fully developed disease (Asiatic cholera), *alternated*, if the symptoms indicate this, with veratrum album x. I have also advised the alternation of these two substances from week to week as a preventive against this disease."

Here it is plain enough that the modifying clause, "if the symptoms indicate this," shows the *intent* can be and could have been as intelligibly expressed (or even more so) with the *equivalent* adverb, "alternatively," and that, therefore, this *equivalent* and not *literal* transcription of the verb *should* have been used; and it is equally patent that Hahnemann meant the alternative between two remedies, and not their rhythmic rotation, when he used the substantive "alternation" (in German, *abwechselung*), which is synonymous and interchangeable with the substantive "alternativeness" (in German also *abwechselung*), for he specifies the alternation of "these two," and not the alternation *of the one with* the other; which conjunction "with" would eliminate the alternativeness (*abwechselung*), or the power of action, or the quality or estate of being alternative. This, therefore, shows but another *literal* translation of a German word which might and does, according to qualifications, mean either a choice between two (alternativeness) or the

combined action of two in rotation, whose correct interpretation in the first place would have clearly pointed to and indicated the meaning, and whose English *equivalent* would have prevented much confusion.

Again, where it is manifestly so possible for two scholars engaged in the same labor of love to differ with the intent of the author under discussion, and also differ with each other (*i.e.*, in so far as their translations from the German, the syntax of which is so comprehensive that each employs equivalents for all similar words and phrases save and except in one single instance, wherein they agree with each other, and with all others similarly engaged, upon a common synonym which is *not* an equivalent, but really the antonym to this one word or its modifications),* it is not inexpedient to compare their several productions further. I therefore beg leave to respectfully submit another paragraph—or at least a part thereof pertinent to this subject—from the *Organon*, as interpreted and translated for us by the gentlemen named.

Wesselhoeft, in his translation of Remark 29, Part III. of Par. 40 (pp. 192 and 193), makes the instructions of Hahnemann to read thus: "After exact experiments and cures of this kind of complicated diseases (referring to psora and syphilis in the same organism), I have arrived at the conclusion that the two diseases are not blended together, but that in such cases they merely exist side by side in the organism, each one dwelling in the parts for which it has an affinity; since their perfect cure is effected by well-timed *alternation* of the best mercurial preparation with remedies for the cure of the itch; each to be administered in appropriate dose and preparation."†

Dudgeon translates this same paragraph as follows: "From careful experiments and cures of complex diseases of this kind, I am now firmly convinced that no real amalgamation of the two takes place, but that, in such cases, the one exists in the organism beside the other only, each in the parts that are adapted to it, and their cure will be completely effected by a judicious *alternation* of the best mercurial preparations, with the remedies specific for the psora, each given in the most suitable form and dose."†

* In paragraphs 62, 65, 69 and 115 of *The Organon*, where one uses the word "counterpart," the other uses its antonym, "opposite."

† The italics are mine.—R. B. L.

Here again the *literal* and not the *equivalent* is used for this one word, "alternation," and is so expressed because of incorrect interpretation of intent or from possible oversight of the German synonyms for *abwechselung* (alternation); for in the German, as well as the English, *abwechselung* (i.e., alternation or alternativeness) is interchangeable or synonymous with *abwechselnd* (i.e., al'ternating, altern'ately or altern'ative); therefore, although in this instance modified or qualified by the conjunction "with" (thus *apparently* demanding conjoined action), it is even more than a probability that, none of his translators having heretofore given us the equivalent in the English for the German verb *abwechseln*—"to alternate"—or for any of its modifications, but have given us the *literal* transcription of said words which are indisputably antonyms to the same, they have likewise failed to interpret the German *sense* in this instance, and have therefore rendered with the substantive, "alternation," the intent implied in *abwechselnd* (i.e., al'ternating with or altern'ately with), whose English qualifications have already, hereinabove, been amply elucidated and discovered; and the elimination of the adverb *alternative* is patent because the qualifying conjunction "with" demands the use of both, if indicated, and not the *alternative* between the two.

The above having special reference to the alternation of, or the alternate use of, two or more remedies in chronic diseases, the practice of alternation of remedies in acute diseases being such a common procedure and the reference to Hahnemann's apparent advocacy of the alternation of bryonia and rhus tox. in neglected typhoid states of Asiatic cholera, and this being a defence of Hahnemann's apparent *intent* against the English rendering or translation of the language employed by Hahnemann in expressing this *intent*, I beg leave to call attention to Note 126 to Par. 246 of his *Organon*, wherein he defines and justifies frequent repetition of remedies in these words: "In *acute* diseases, the time for the repetition of the proper remedy is regulated by the rate at which the disease runs its course; thus, in cases of cholera, the most rapidly fatal disease known to us, it is necessary, in the beginning, to give one or two drops of a weak solution of camphor every five minutes, in order to insure speedy and certain relief; while in the more developed stages we may be called upon to employ doses of

cuprum, veratrum album, phosphorus, etc. (x0) every two or three hours; or to give arsenicum, carbo veg., etc., at similar intervals."

The question, then, naturally arises, wherein is he who alternates bryonia and rhus tox., under the above-mentioned circumstances, justified, either in fact or apparently, through this advice, to frequently repeat the indicated remedy? Or, if not so justified in fact, what does Hahnemann mean by using the term "alternating" in this apparently unqualified manner, or does he herein (as one exception) mean to justify the alternation of remedies in the sense in which we are so prone to interpret him and to practice? If he ever meant to even insinuate such an interpretation, his other references to this verb and its modifications would quickly prove such interpretation correct, while if he did not mean alternation, as we understand the term, the words already spoken will confute his maligners at every point; and in this behalf we find that Par. 272 of his *Organon* throws some light upon this matter in the following words: "In the treatment of disease only *one* simple medicinal substance should be used at a time, and some homœopathic physicians have tried the plan of administering two medicines at a time or nearly so (alternation, as we understand the term), in cases where one of the remedies seemed to be homœopathic to one portion of the symptoms of the disease, and where a second remedy *appeared* adapted to the other portion; but I *must seriously warn my readers against such an attempt, which will never be necessary even if it should seem proper.*"*

After such unqualified admonition to the contrary, it is clear that in the use of the verb *abwechseln* ("to alternate") Hahnemann *never* found such *practice* necessary, and that while, "in the most acute diseases," the remedy may be repeated every five minutes, and in such cases the symptoms may change and therefore indicate another *simillimum* than the first, or even, after the use of the second, a repetition of the first may be more indicated than those of any other remedies, Hahnemann clearly *meant* and *intended* to imply the *succession* of remedies *as their synonym in disease-symptoms indicated*, and only then after a *restudy* of the case, and therefore at no time taught, either in

* The italics are mine.—R. B. L.

terms or by implication, in any of his writings, the rhythmic rotation of remedies as we understand *alternation* to imply.

But since we are now considering the acute diseases, and since we have found him advising—when indicated—frequent repetition of remedies, it is fair to presume that examples of *apparent* alternation in the most “acute diseases” exist, and will substantiate the assumption of misinterpretation and consequent mis-translation of his *intent*, or prove that we, and not the translators, are wrong and in error; and this is found in the most megascopic elucidation of “the alternate administration of aconite and the tincture of raw coffee” where, on page 695 of the “Lesser Writings” and on page 200 of Vol. I. of this “Materia Medica” (translated by Hughes and Dudgeon), he says: “This red miliary (rood-vonk) is quite a different disease from scarlatina, requiring quite different treatment. *Beladonna* naturally does no good in it, and the ordinary routine practice allows the majority of patients to die with it. These might be cured by the *alternate* administration of aconite and tincture of raw coffee; the former for the heat and increasing restlessness and agonizing anxiety; the latter for the excessive pains with the lachrymose humor. The aconite should be given in the decillionth-fold dilution of the juice and the raw coffee in the million-fold dilution, both in the smallest portion of a drop for a dose, the one or the other, according as they may be indicated, given every twelve, sixteen or twenty hours.”

This hardly appears the equivalent of our understanding and practice of *alternating* two medicines, and yet this is a sample of all his prescriptions which have been transcribed for us and wherein he *apparently* advocates alternation, and where his translators, not interpreting his “*sense*” and conveying it to us in its English *equivalent*, have confined their equivalents to all* other words than his verb “to alternate,” and its modifications; for in the quotation just made, as in all others found, the qualifying preposition “or” irrefutably nullifies the possible *intent* or implication to necessarily use both aconite and raw coffee, so that the conjunction “and” is absolutely qualified by the clause following (*i.e.*, “according as they are indicated”); and the fact that very often, in the experience of every homœopathic

* Except, as stated, in paragraphs 62, 65, 69 and 115 of *The Organon*.

physician, the *first* exhibited (of two *apparently* equally well-indicated remedies) eradicates the disease *in toto* and leaves no alternation nor alternative for two remedies.

While most respectfully submitting such an array of investigated quotations, and taking such positive grounds against the translations referred to, I wish it to be understood that I do not claim or assert that the verb "abwechseln" does not, *per se*, mean "to alternate," for that is just what this word, *unqualified*, does mean; but I *do* claim, and most emphatically assert, that Hahnemann, where quoted, *qualified* this verb or its parts, and thus changed, and *intended* to change, unequivocally, its meaning, and that, therefore, only the *equivalent*, and never the *literal*, translation should be used; for this qualifying of the German, or the rendering of same into the English *equivalent*, is as much the perfection of a translation as the rendering of any other part of their production; so that the present rendering of the verb "abwechseln" (whose qualifying clauses were, apparently, *un-considered*) is quite as serious a mistake as to assert that a horse is "*fast*" and not *qualify* the assertion by a previous or subsequent converse or clause which shall designate whether the horse is "moving rapidly" or is "firmly fixed" (*i. e.* is securely hitched or tied to something stationary and immovable).

With such an array of investigated quotations, I beg leave to submit and leave the subject with those possessing and understanding the German idiom and syntax of these several productions of THE ONLY Hahnemann, and will feel amply repaid for my endeavors to clear up this mooted question should others undertake the remainder of the work in this behalf, only according to me the right to enjoy their amplifications, and that, through these efforts, many may again see their way clear to the practice of a pure and logical homœopathy.

PULSATILLA IN CHRONIC DYSPEPSIA.—A servant girl, of 22 years, had suffered for six years from disturbed digestion and tenderness of the epigastric region. The other symptoms were not to be elicited, for her other functions were apparently normal. She received pulsatilla 3x; for fourteen days there was a decided amelioration. She received another supply of the remedy, and from that time she has continuously improved.—*Vratch Gomeopat*, No. 8, 1898.

HEAD INJURIES.

BY CARL V. VISCHER, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society, State of Pennsylvania, Pittsburgh, Sept., 1898.)

THE presentation of this paper is prompted by the not sufficiently recognized importance of giving particular attention to all injuries of the head, as oftentimes traumatisms, which are apparently of the most insignificant character, on careful investigation prove to be of the most serious import, if not directly, at least indirectly, so far as subsequent changes are concerned, which, if not leading to a lethal termination, greatly affect the future health of the individual.

The head is as much exposed to accident as any other portion of the body; hence, injuries here are of common occurrence. The skull, by reason of its anatomical conformation, deflects the force of many ordinary blows. Early in life, before complete ossification of the bones and sutures occurs, the cranium is exceedingly elastic. This, together with the fact that it is formed on the principle of an arch (consisting really of a series of arches, or a dome), also makes it less liable to suffer from extrinsic force. After ossification has taken place, we find considerable motion still to exist at the lines of suture, and which persists to varying degrees in different individuals until late in life. The fact that the bones are composed of three plates, together with air spaces at several points, also increases their resiliency, so that a fully-developed skull possesses not a little elasticity. We furthermore know that certain portions of the skull are decidedly thicker than others; and it is a peculiar fact that this additional protection exists particularly at those points most exposed to trauma.

Notwithstanding the above stated facts, we now realize that fractures of these bones occur with much greater frequency than was once supposed; hence the importance of always suspecting such to be the case until events prove otherwise. Once again the credit falls to the present technique of operative interference, which no longer makes us dread a wounded scalp, but, on the other hand, permits of the most liberal exploration

of the entire skull surface; and we may go a step farther by adding, largely of its cavity.

In looking over the text-books of but a few years back, we find a list of stereotyped symptoms given as characteristic of skull fracture, and these are generally sharply defined from a similar list due to so-called "cerebral concussion," operative interference being only counseled where the former are present and strictly contraindicated in the presence of the latter. It is the lasting impression of these signs, such as unconsciousness, changed pupils, and a condition rapidly approaching the moribund, which to-day we know are so often absent or late in their appearance, that leads many of us to overlook entirely the possibility of fracture.

These differential guides, thus formally regarded as of so much significance, in the light of more recent research (especially that of Ferrier, Monk, Horsely and others in cerebral topography), are to be utterly disregarded. These symptoms, once considered so characteristic, are seldom present, save in extensive lesions, and not always then. We now know that the symptoms will vary: first, according to the region involved; second, according to the amount of hæmorrhage and laceration of the cranial contents; and even these are but general guides, inasmuch as we frequently find extensive fractures without commensurate cerebral manifestations.

This being true, it will be readily appreciated what care should be exercised in all cases of head injury, as only too often the lesion is not recognized until late, when such symptoms as above mentioned present themselves, and when the golden opportunity has probably passed beyond reach.

From the present state of knowledge of cerebral pathology it is, to the mind of the writer, much the safer principle to suspect some lesion of the skull until absolute evidence to the contrary is at hand; and if such is not the case the patient should have the benefit of the doubt, and the skull be freely explored. Particularly is this advisable, as no potent reason exists for not doing so, the operation, *per se*, being no argument to the contrary.

As to the technique of the operation, little need be said. If a wound exists, it is to be sufficiently enlarged to permit of careful exploration of the neighboring surface. In cases of no

wound, oftentimes a hæmatoma is found, and this may present such evidence as to make the examiner feel confident of the presence of a fracture, yet on incising it will be found to be nothing save blood extravasation beneath the aponeurosis of the occipito frontalis. These hæmatoma are at times most confounding; still, a simple incision solves the problem, and in case of no fracture the first step of good surgical treatment for extravasation of blood has been instituted. Where no external manifestation of injury exists, there are usually present some subjective symptoms, such as pain, or, in case of internal bleeding, some localizing sign will be found.

During the past few years it has fallen to the lot of the writer (in hospital and private practice) to meet some fifty cases of skull fracture, from which the following are taken as illustrative of the above argument.

CASE I.—C. W., aged 45 years. On the evening of May 18, 1896, was thrown from a wagon, striking on his head. He was picked up in a dazed condition and taken to his home, by which time the shock of the accident had, for the most part, passed off, when attention was given particularly to a few bruises about the left shoulder and hand. He complained greatly of headache, which did not subside under the remedies given. Less than twenty-four hours after the accident the pains in the head became aggravated to such an extent as to lead to a second examination; the first, shortly after the reception of the injury, proved negative. At this time some swelling was discovered over the left temporal region, and a slight skin abrasion on the frontal eminence of the same side. The patient was beginning to show some drowsiness; would speak only after being called in a loud tone of voice. Otherwise, however, no special symptoms, the mind being perfectly clear.

Suspecting some intracranial lesion, we were asked to see the case some thirty-six hours after the accident, and found him perfectly conscious and rational, complaining of nothing save headache. It was observed, however, that there was a tendency toward drowsiness. Pulse was slow and full, temperature normal, as was pupillary reaction; no paralysis nor gastric symptoms; knee-jerks slightly exaggerated, especially upon the right side. Examination of the head revealed abrasions of forehead and an induration which had gradually become more marked since the accident. Exploratory incision was advised, which was immediately done, revealing an extensive comminution of the squamous portion of the temporal and of the

parietal, also a linear fracture of the frontal bones, the latter extending around to the opposite side, a distance of not less than eight inches. After removal of the fragments and the depressed frontal bone, the wound was treated in the usual manner, and the patient made a rapid recovery.

CASE II.—A. J., aged 27 years. On the 6th of June, 1898, made a misstep, falling down a flight of fifteen carpeted steps, striking his head on the hall floor, which also was heavily carpeted. He got up complaining of severe pain at the site of injury. Owing to some little shock he retired at once. The following morning, the headache not having abated, but rather increased, a physician was summoned, who prescribed hot compresses. His condition not having improved by evening, I was asked to see the case, and found him suffering from severe hemicrania on the left side, which had persisted since the accident, and was informed that he had vomited immediately after the injury. Attendants had noticed some slight rambling in his conversation during the previous two hours. The face was flushed, conjunctivæ somewhat injected, pupils rather sluggish in reaction, patellæ reflexes exaggerated; no evidence of paralysis, a slight abrasion on the left side of forehead, frontal and temporal regions swollen but no bogginess. Pulse and temperature normal. Recommended exploration, which was done at the St. Luke's Hospital, disclosing a depressed fracture extending from the external angular process of the frontal bone, backward and upward, for a distance of four inches. A button of bone was removed and the depression relieved, when it was found that the dura also was lacerated. This was united and the wound closed except at its most dependent point, where a drain of iodoform gauze was introduced. The patient made an uneventful recovery.

CASE III.—E. F., aged 60 years. While coming down a flight of stairs slipped and fell, sustaining a slight laceration of the scalp. She was picked up in an unconscious condition, from which she soon recovered, after which the scalp wound was united by several interrupted sutures. She progressed apparently well until some sixty hours after the accident, when she again lost consciousness. We now saw the patient for the first time, presenting a typical picture of brain compression. She was removed to the St. Luke's Hospital, where the skull was exposed, showing a marked depressed fracture. This was relieved, but unfortunately too late to prove of any permanent avail, the patient rallying for a few hours, after which coma again developed, in which she gradually passed away.

CASE IV.—A. O. V., aged 45 years. While working on a roof made a misstep, falling to the ground, a distance of about twelve feet. Was taken up and removed to his home in an

unconscious condition, but soon regained consciousness, and to all appearance was doing well until during the evening, when he was suddenly taken with a convulsion, followed by projectile vomiting and some bleeding from the left ear.

We saw the patient the following morning, and could learn little or nothing as to the particulars of the spasm; examination, however, showed quite a large hæmatoma situated about the left temporo-frontal region. Fracture was, of course, suspected, and the patient advised accordingly. He was admitted to the St. Luke's Hospital, where the skull was exposed at the site of the injury, demonstrating a linear fracture some five inches in length; the trephine was applied, when a large extra dural clot was disclosed. The operation was completed in the usual manner, the patient making an uneventful recovery.

CASE V.—P. B., aged 4 months. Father was carrying child while walking along a board path, when he stepped on a loose board, and, losing his balance, fell over an embankment some five feet high. Fearing lest he would fall upon the child, he let it go, when it struck the ground, probably head first. It was stunned a few moments, after which it had a "crying-spell," which was followed by an exceedingly fretful condition.

For fear that it had sustained some serious internal lesion, it was referred to me, when we found some œdema of the entire posterior and left half of the head. An exploration of the skull was made, disclosing a linear fracture seven inches long, but no apparent depression. The line of fracture, however, was widened by operation, doing away with any possibility of compression. The child rapidly regained its normal state of health.

CASE VI.—W. W., aged 14 years. At the age of 8 months he fell, striking his head against the kitchen range. He was seemingly well for twelve hours afterward, when he became drowsy and had a series of left-sided convulsions, continuing for several hours, followed by coma, from which he woke up with left-sided hemiplegia. During the week following convulsions frequently threatened in the paralyzed limbs, but did not develop. The hemiplegia persisted for a month, and then partially cleared up. At intervals of three or four months thereafter he would have convulsions similar to the first, with the subsequent paresis of the left side. Of late these have been more frequent, momentary in their duration, and with no paralysis following. With this are attacks of the *petit mal*.

Localization by my colleague, Dr. Bayley, indicated that the face centre was the principal seat of injury. At surgical exploration there was found an irregular thickening of the skull, to which the dura was adherent, and with positive evidence of former fracture. This, it will be recollected, was more than

thirteen years after the accident occurred, which was early in infancy. This case was operated more than two years ago. The boy is at present in perfect health, and has had but three convulsions during the interval, each of which was provoked by over-indulgence in bananas.

This series of cases has been selected to represent the types clinically met with: First, Those with entire absence of scalp injury; Second, Those with a slight wound accompanying a badly-depressed break; Third, Remote effects due to brain changes secondary to unrecognized fractures.

These are but a few of many instances that could be mentioned. They suffice, however, to show the dangers, both direct and remote, of the character of injuries under discussion, and justify, we believe, the following conclusions:

1. That fracture of the skull is more common than it was once believed to be.

2. It not infrequently results from comparatively slight injuries.

3. Oftentimes the fracture is out of all proportion to the external injury, which may be so slight as to almost escape detection.

4. A wound is not at all essential to the existence of a fracture.

5. Symptoms of brain pressure may not develop until many hours after reception of the injury.

6. The presence of a fracture should be suspected in every instance until the opposite is proven.

7. And for this reason an exploration of the skull should be made in all such cases.

RHUS TOXICODENDRON IN PEMPHIGUS.—A little boy, of 6 years, presented an eruption of pemphigus on his scalp, face and back of his neck, as well as on his hands and on several other regions. It persisted for some time; the vesicles burst open and became covered with blackish scabs and broke out anew. The child was well-nourished otherwise and perfectly healthy. Around the affected spots there was itching and great burning. *Rhus tox.* 3x was given. The irritation of the skin in the course of the first week began to disappear. With exception of the hairy parts (scalp), where another eruption appeared, the pemphigus was disappearing. During six weeks the remedy was continued, at the end of which time the scalp was wholly free from any eruption.—*Vratch Gomeopat*, No. 8, 1898.

RETRO-DISPLACEMENTS: VENTRO-FIXATION.

BY J. H. M'CLELLAND, M.D., PITTSBURGH, PA.

(Read before the Homœopathic Medical Society of Pennsylvania, Pittsburgh, Sept., 1898.)

THE literature upon this form of displacement is almost as extensive as the malady itself, which is saying a great deal. It is not the purpose of this paper to take up the subject *in extenso*. Any thoroughly up-to-date work on gynæcology (and that of our own J. C. Wood is second to none) will give a sufficiently full exposition of this prevalent lesion. Not only would I refer you to the admirable treatise of Professor Wood, which is a pleasure to peruse, but I would suggest a careful examination of the paper presented to the American Institute of Homœopathy at its last meeting by our able gynæcologist, Dr. O. S. Runnels, of Indianapolis. This paper is a classic, and should be read by every one who wishes to have a clear idea of the principles and practice of this branch of gynæcology. Not that I agree with all of the suggestions in that paper, particularly those having reference to the delaying development of the uterus in growing girls. To my mind its physiology is bad, while its pathology is worse. This paper you will find reprinted in the September *Medical Century*, and also in the *Journal of Obstetrics*.

The matter I have in mind at this time refers to that class of cases wherein any amount of internal treatment, or local treatment, such as applications, tampons and supports of various kinds, will have no apparent beneficial effect—in fact, where many of these measures will not be tolerated at all. This narrows us down to a very serious and special lot, as we might say.

The uterus is nearly always congested and enlarged. It is in many instances adherent, and the case is very often complicated by the presence of a prolapsed ovary, and this presence in the Douglas cul-de-sac is made manifest by reflexes and local pains of a most distressing character.

It will not require many words to convince the skeptic, if such there be, that this form of displacement, attended by in-

finite suffering and discouragement, is practically beyond remedy, save by a surgical operation. The effective measures that have been suggested for the permanent cure of this class of displacements are not many, and will be but briefly mentioned. Most prominent among these is the method suggested by Wylie and Baer of doubling the uterine ligaments upon themselves, by which they are shortened and made more tense; that of Alexander, in which the round ligaments are drawn out of the inguinal canal and shortened for the same purpose, namely, of drawing the uterus forward; the operations per vaginam, by which fixation is secured or the uterus is doubled forward by ligature; and, lastly, what is known as ventro-fixation or hysterorrhaphy. This, of course, leaves out the all-too-radical measure of uterine ablation.

Of the above measures, it is becoming evident that the operation of Alexander and that of hysteropexy have alone survived. As the facts continue to come home, it will further appear that the operation of Alexander will be less and less frequently performed, and that of ventro-fixation will almost stand alone for the permanent relief of retro-displacements of the character we are considering.

A rather careful study of not a few cases leads me to the belief that the very painful conditions which we find are for the most part due to a more or less complete prolapse of the ovaries. The pressure and rough usage to which the ovary is subjected in its malposition cannot fail to produce many and great disturbances of body and mind. It has been said by competent authority that an ovary that has been prolapsed for any considerable length of time seldom escapes irreparable injury, ending in hopeless degeneration.

Taking for granted, then, that we have a case which has resisted all milder measures, or would resist them if tried, we must proceed to the only rational method left to us, if we are to afford such relief as our art enables us to offer, namely, a ventro-fixation. Although this is by no means a complicated operation, it yet affords some scope for the careful, discriminating surgeon.

The important points to be considered are: The selection of the best location for the introduction of the sutures in the uterus and the abdominal parietes as well; the suture material

that will secure the best results; and, finally, the manner of engaging the abdominal wall and bringing it into close and permanent contact with the uterus.

My method of doing the operation is about as follows: The patient is in the Trendelenberg posture. A small opening is made through the abdominal wall, usually two inches long, through which two fingers are introduced. The ovaries are examined, and one or both removed if necessary. Adhesions are now broken up and the uterus is brought well into the abdominal opening. Here it is retained until the sutures are introduced. I usually select the anterior aspect of the uterus well up to the top of the fundus, for the planting of the sutures.

This point is selected in the belief that in case of pregnancy it would create less embarrassment to the developing uterus than to have the sutures in the posterior wall, as recommended by some authors. It is true the posterior suturing might secure a more desirable position in the pelvis for the time being; but if pregnancy should ensue, the difficulties would be greater. The point selected in the abdominal line for the passage of the sutures is well off the bladder, but not so high as to drag the uterus too heavily. It has been well said that very slight traction only is necessary to keep the uterus in its anteverted position, the weight of the intestines, etc., having much to do with maintaining the normal position. This must be kept in mind. I formerly included the whole thickness of the abdominal wall in the sutures. Later, I modified this so that only the subcutaneous tissues were taken in, burying the stitches. Of late—say the last year or two—I have taken pains to limit the suturing to the peritonæum alone. I am satisfied that this possesses many advantages. The peritoneal lining of the abdomen is movable and allows a certain amount of motion to the uterus to which it is attached, and which must be of the greatest advantage. The suture material generally employed is silk. Catgut, even if chromicised, has but a brief life, while the silkworm-gut is liable, in my experience, to cause irritation by its wiry, unyielding nature. Silk lasts the longest, with the least unpleasant after-effects. Two sutures are usually sufficient. The wound is then closed with catgut and silkworm, as in any cœliotomy. During the last year I find the record of thirteen cases in my hospital practice, and the results are invariably good.

A CONSIDERATION OF THE AMMONIUM SALTS WITH SOME
COMPARISONS.

BY W. H. A. FITZ, M.D., PHILADELPHIA, PA.

(Read before the Homœopathic Medical Society, State of Pennsylvania, Pittsburgh, Sept., 1898.)

IN considering a drug, or family of drugs, endeavor to study their elective affinities, as they give form, character and meaning to their symptoms. Any peculiar, striking or uncommon symptom should be carefully noted, as this may give us the clue to its homœopathic adaptability in some pathologic state heretofore unsuspected or unknown. Find the *red string* in every pathogenesis and we have the key to many symptom puzzles.

Looking to homœopathic adaptability we find the ammonium salts best suited to fat, sluggish, bloated patients, who are indolent and lead sedentary lives. The ammonium mur. suits sluggish people whose trunk is fat, the legs being disproportionately thin. This is a constitutional difference from the carb. Ammonium carb. produces a condition of the blood similar to scurvy. Hæmorrhages from the mouth, nose and bowels show its disintegrating influence. The muscles become soft and lax, with marked emaciation. A strong elective affinity of the salts is for the mucous membrane. The effects range from simple inflammation to a complete destruction of the epithelium, leaving a raw, burning, ulcerated surface. Diseases producing similar effects might find their simillimum in these salts. Upon the skin their effects vary from a papular to a vesicular or ulcerative condition.

Individually considered, *ammonium carb.* produces a scorbutic condition. The powers are weakened; blood tissue degenerates; dark, fluid-blood hæmorrhages appear, and a hectic form of fever. In any disease where there is a deficient oxygenation of the blood ammonium carb. should be thought of. There will be somnolence or drowsiness; large mucous râles in lungs, grasping at flocks; blue or purple lips and brownish tongue. It may bring about reaction in cerebro-spinal meningitis where the patient, stricken down by the violence of the disease, is

cold, non-reactive, stupid and cyanotic, with very weak pulse. It is useful in dilatation of the heart, where the patient suffers from ascending a height. A warm room is unbearable. There may be palpitation with dyspnoea and epigastric retraction and possibly cyanosis. The lax effect of the drug may be seen in pneumonia, where there is marked debility and tendency to heart clot. In chronic atonic bronchitis favoring emphysema much mucus in the lungs, dilated tubes and pulmonary oedema. The patient is weak, sluggish in his movements, coughs continually, expectorates with great difficulty or not at all. Drowsiness, and even muttering delirium may be present. In scarlet fever it is indicated by this same tendency to somnolence, with the dark-bluish color of the tonsils; swollen internal and external glands. The child sleeps with his mouth open in order to breathe, and starts from sleep from a stoppage of breath. The rash is miliary. In nasal catarrh the nose is stopped up at night and the patient awakes gasping for breath; worse from 3 A.M. to 4 A.M. The cough is dry and tickling, with hoarseness, and great oppression from mucus in the chest. The nostrils are raw and sore. The coryza is excoriating, and there is rawness and burning down the sternum. The sputum is slimy and contains blood flecks. Ammonium carb. is especially useful in winter coughs. In fat, lax, torpid patients compare amm. carb. with amm. mur., arn., ars., aur. mur., bar. c., bell., calc. acet., calc. carb., cinch., ferr., graph., lyc., merc., puls., sep., sil., sul., thuj.

Ammonium Mur.—Its effects are mucous-membrane irritations; disturbances of the blood circulation, worse especially in a warm room; blood ebullitions, violent throbbing in the arteries, accompanied by anxiety and weakness, as if paralyzed. There is a periodicity of symptoms, as in chills and fever where the paroxysms return every *seven* days.

Nervous symptoms are pain in the left hip, as if the tendons were too short, making the patient limp when walking; gnawing in the bones, worse sitting. In the joints, constrictive sensations. Sensation as if the hamstrings were too short, better from continued motion; it, therefore, effects the fibrous tissues about the joints. It is useful in chronic sprains.

Female organs: The inguinal and hypogastric regions are affected, suggesting ovarian and uterine irritation. There is

tensive pain in one or the other groin; she feels as though she had sprained herself. There are stitches, cutting and soreness, but most characteristic of all is the strained feeling in the groin, which makes her walk bent. The muriate stool, which crumbles at the anus, is a usual accompaniment. A characteristic leucorrhœa is brown and lumpy or clear and albuminous, following every urination.

Nose: There is coryza. The nose is more "stopped-up" at night than in the day. One side is usually stopped-up at a time. The discharge is watery and excoriating, making the inside of the nose and upper lip sore. The throat is swollen so that the patient cannot open his mouth; and throat and mouth are filled with a viscid phlegm of difficult expulsion. Throbbing in the tonsils is characteristic. This makes it useful in scarlatina and tonsillitis, where the faucial symptoms produce almost strangling.

Chest: The cough is violent, which excites the salivary glands, causing the mouth to fill with saliva; there is hoarseness, with burning and rawness in the larynx; coldness between the shoulder blades; heaviness in the chest; a sensation as of a lump in the chest; spots in the chest burn, throb and beat with the pulse.

Ammonium mur. has a specific action upon the liver. It is useful in chronic congestion of the liver; the stools are coated with mucus and the spirits depressed. Constitutionally, compare ammonium mur. with bry., calc. carb., calc. fluor., calc. phos., phos., puls., rhus tox. and sepia.

Ammonium brom. is a unique salt, which requires more extensive proving. Its elective affinities seem to be for the brain, the cervical and dorsal portion of the cord, the eyes and nose.

It becomes useful in cerebro-spinal and basilar meningitis, and certain severe occipital headaches; also in the peculiar spasmodic cough attendant upon cerebro-spinal congestions. Consider it in epilepsy with basilar congestion.

In brain anæmia, where the mental symptoms indicate the anæmia due to diminished calibre of the blood-vessels. Its symptoms indicate it in strumous ophthalmia, conjunctivitis, corneitis and leucoma. It is useful in swelling of the edges of the lids and inflammation of the meibomian glands. In post-nasal catarrh, where the discharge is thick and stringy. Its

cough is sudden and spasmodic, with pains in the stomach. It comes at intervals of a few minutes, lasts for hours, and is worse when lying down at night. There is a sensation of tickling irritation in the larynx, with a distinct whoop; and, if there be any expectoration, it is a stringy, tough mucus.

Ammonium caust. may be thought of in aphonia, with burning rawness in the throat.

Ammonium acet. has a clinical reputation for curing dysmenorrhœa, but as no provings have been made its indications cannot be given. It produces a profuse flow of urine containing sugar, which might make it a possible remedy in diabetes mellitus.

Ammonium phos. has been found very useful for chronic gouty nodosities.

Ammonium picrate is valuable for the headache, accompanied by marked nervous depression, before, during or after the menstrual epoch.

How the genius of Hahnemann is growing more effulgent as physiological research is giving us the interpretation of symptoms! Every recorder of symptoms should be a skilled anatomist, physiologist, physiological chemist and physical diagnostician. He could then give exact definition to the symptoms as given by the prover. In the differential comparison of symptoms we must keep in mind the general action and modalities of the drugs compared, as they will give us the clue to the interpretation of the particular symptoms.

Let us consider a few drugs in comparison with these ammonium salts.

Compare ammonium carb. with antimon. tart., antimon. ars. and antimon. iod. in any disease where there is deficient oxygenation. Ammonium carb. with arnica in typhoid states when the patient is drowsy, heavy, and falls asleep answering questions.

Ammonium carb., arnica and bovista are all of use in poisoning by charcoal fumes. In scarlatina, both amm. carb. and bell. have the right side of the throat affected, bright red rash and drowsiness; but the differences are that in amm. carb. the rash is miliary; the throat is a darker red; the drowsiness is more complete. In bell. the eruption is smooth; the throat a bright red; the drowsiness alternates with wildness, starting and crying out in sleep, and restless delirium.

Amm. carb. and apis are indicated in low types of scarlatina with somnolence; both have miliary rash, but apis has puffiness of the throat and dropsy of the uvula. Apis also has inflammation or irritation of the cerebral meninges, indicated by a sudden shrill cry and rolling of the head.

Amm. carb. and lach. both have blueness of the surface, somnolence, engorgement of the neck and dark-red or blue swelling of the throat; but lach. has extreme sensitiveness of the surface to *light* pressure. Amm. carb. and rhus tox. both have dark throat and drowsiness; but rhus tox. is more restless and affects the left parotid, while amm. carb. affects the right. In nasal catarrh, consider amm. carb. with kali bich. and ambra grisea for soreness and rawness of the nostrils and bluish mucus.

Amm. carb. has the 3 A.M. aggravation in common with the kali salts. In the rawness and burning down the sternum of amm. carb. consider carbo veg. and caust. Amm. carb. and laur. both have blood-flecked expectoration. Amm. carb., arnica, sulph. ac., amm. mur. are useful in sprains, when the joint is hot and painful. When thinking of ammonium mur. for ulceration of the heels, with tearing, stitching pains, worse at night in bed, better by rubbing, think also of puls., caust., manganum, ant. crud., ledum, graph., nat. carb., allium cepa and sabina. Manganum in rheumatic patients when the weight cannot be borne on the heels. Ledum, graph. and nat carb. cause blisters on the heels. Allium cepa cures ulcers caused by friction of the shoe. Sabina is suitable in plethoric women with rheumatic inflammation. Medorrhinum, when there is marked soreness of the soles on walking. In gouty nodes compare ammonium phos. with aur. mur. natr., benz. ac., bry., calc. carb., calc. fluor., caust., form., ledum, lith., lyc., rhod., sab., sil., staph., sul.

THE REMOVAL OF CATARACT WITHOUT THE AID OF THE KNIFE.—The writer investigated the claims made by the manufacturer of a preparation of cineraria maritima, as expressed in widely circulated advertisements, and found that "so far as he could learn there is no evidence to show that cineraria maritima is of any value as a curative agent in cataract, and from the action of the Walker Chemical Company they evidently are not anxious to have the drug properly tested."—J. Ellis Jennings, St. Louis, Mo.—*American Journal of Ophthal.*, November, 1898.

TREATMENT OF RECTAL DISEASES.

BY W. G. STEELE, M.D., PHILADELPHIA, PA.

(Read before the Homœopathic Medical Society, State of Pennsylvania, Pittsburgh, Sept., 1898.)

IN considering what subject might interest this organization I finally concluded that an outline of treatment of the commoner rectal diseases, met by the medical man, would be interesting and possibly instructive. I well remember some years ago, on my return from a course of instruction and study in this special line of work, meeting a professional friend, who said he had a case of hæmorrhoids for me, and who asked what line of treatment I would probably follow. I was then impressed with the idea that there was only one way to successfully treat hæmorrhoids, and that was "cut them out." I so informed my friend, who remarked that he was afraid his patient would not submit to that treatment, and so it proved, the patient going to other hands and getting relief. I soon saw that while "cutting them out" was good treatment from a surgical point of view, yet patients demanded a treatment which was milder, and not likely to cause confinement to the house. I then commenced the so-called "injection treatment," and have used it, with very satisfactory results, for the past six years, using a number of different formulæ, phenic acid, however, in different proportions being the main ingredient; a formulæ which I formerly used quite extensively being a 10 per cent. sol. of phenic acid in aqua dist. and hamamelis Virginica. My experience teaches me that the method of using is of more importance than the formulæ. By this I mean the injection should be made into the body of the hæmorrhoidal mass, avoiding the connective tissue. At present I am using an extremely satisfactory formulæ, which I obtained in a manner that precludes my publishing it at this time.

While I have been injecting hæmorrhoids for a number of years without meeting any serious complications, I am aware that unfortunate results do follow, even in skillful hands; but I am constantly watching for manifestations of trouble, and on the first signs of trouble I carefully examine and use every

care to obviate it; yet from what I can learn of the complications which at times follow the proper use of this line of treatment, they are seldom, if ever, more serious than would be the original operation of ligature, or clamp and cautery.

Cases are met which require other methods of treatment than injection. In quite extensive cases I prefer the clamp operation, using a Lind clamp, which avoids the necessity of using the cautery, the operation consisting of dilating the sphincter, grasping the mass to be removed with a T forceps, everting it and applying the clamp. The Lind clamp when closed crushes the tissues in a tongue and groove joint; after, say, a minute or more, remove the clamp and cut along the middle line of crushed tissue; if properly done there will be no hæmorrhage; apply sutures as necessary; apply dry dressing with firm perineal pad. This is a very satisfactory method, little or no blood being lost, and when used as above outlined there will be no occasion for the barbarous burning with the cautery, and consequently no eschar to slough off, with unexpected and violent secondary hæmorrhage, which sometimes follows the clamp and cautery operation.

Many patients tolerate hæmorrhoids for years, until by some accident they become strangulated, when the suffering thus induced causes them to seek relief. In these cases my practice is to first administer nitrous oxide gas in my office, stretch the sphincter, and thus easily reduce the mass. In the reduction of hæmorrhoids a little practical point of great value is to press the presenting mass firmly between the finger tips, squeezing the blood out of it as much as possible, while at the same time directing the general pressure of the mass in the direction it should go to return within the sphincter. The combination of the stretching and the use of the above manœuvre renders easy what would otherwise be an extremely difficult and painful procedure, and is accomplished in a very short time. I generally use a plug of absorbent cotton with some ointment on it, supported by a perineal bandage, after this operation.

Another mode of procedure that I frequently follow, particularly when operating for some other lesion, as lacerated cervix or perinæum, etc., is what is known as the slit method of Dr. Pratt. This consists of trimming a fine line of mucous membrane directly across the most prominent portion of the

hæmorrhoidal mass, and with the points of the scissors teasing out the venous network and enucleating it. In case of severing an arterial twig, either ligate or apply torsion to the bleeding vessel. I generally follow this operation by the insertion of a plug of sterilized China silk, as the pressure and the silk controls any oozing that might follow.

There is a remarkable property connected with the use of raw silk, properly sterilized and used in this manner. The powerful influence exerted by spider web in arresting hæmorrhage has long been known, and undressed silk, which is substantially a similar substance, it has been found, also possesses this remarkable property. By its mere presence and contact, in some unknown manner, it acts as a powerful styptic. As a matter of personal experience I once saved a life, or at any rate a formidable surgical operation, by merely inserting some of this substance in the bony cavity, in a hæmorrhagic patient, from whom a tooth had been extracted, and in which the hæmorrhage was altogether uncontrollable by other means. I had previously packed the cavity tightly with cotton in connection with a styptic, but notwithstanding this the hæmorrhage continued, while after the application of the silk the hæmorrhage almost immediately ceased, and did not recur after its removal about forty-eight hours afterward.

I well remember the surprise of one of my surgical friends, who had invited me to assist him at an operation for hæmorrhoids, when I demonstrated to him this so-called slit method. I had to assume all responsibility before he would entertain the idea, as the departure from orthodox lines was so radical; but after he witnessed the ease and simplicity of the operation he became an enthusiastic advocate of this method, and informs me that he has secured some beautiful results from its performance.

In *external* hæmorrhoids the only treatment I use is to insert a sufficient quantity of eucaine, 5 per cent. sol., incise the hæmorrhoid, turn out the clot, pack lightly with gauze, adjust firm perineal support, and the patient will "rise up and call you blessed."

Fissure is one of the most painful and yet easily-corrected conditions met with in rectal practice. The treatment in these cases consists of the administration of nitrous oxide gas, stretch-

ing sphincter, and frequently of drawing a bistoury lightly over the bottom of the fissure, to be followed by the application of a stimulating ointment on gauze, lightly laid in the track, and changed as required; this will be found to be all that is generally required to cure cases of this disease in short order.

Pruritus Ani.—I believe this affliction to be generally due to a minor organism, as, before reaching this conclusion, I had examined and found cases with apparently nothing to correct, and yet suffering more torments than could be readily described. In these cases I have found good results follow the use of different ointments and lotions, as quinine sulphate in lanoline, lotio niger, or a combination of calomel, zinc oxide, starch and lanoline; but the secret of curing these cases is in the manner of preparing the patient for the treatment, which I believe to be as follows: Three times a day the patient is to apply cloths, wrung out of water as hot as can be borne (this greatly increases the skin absorption), to be immediately followed by the use of the application selected; usually a couple of days will suffice to mitigate the sufferings about 50 per cent. In *itching hæmorrhoids* I find the application of nitrate of silver in solution to prove quite satisfactory.

Rectal Prolapse.—Examine any of the text-books on rectal surgery, and the treatment advocated will be found to be as follows: Linear cauterization with Paquelin's cautery; excision of a part or all of the prolapsed tissue; or the application of fuming nitric acid to the mass. Now in these cases, and they are more common than is generally supposed, I have found the injection treatment to be much simpler and perfectly satisfactory, as by depositing a few drops of the fluid into the prolapsed tissue an absorption of this area is produced; and when repeated at intervals of about a week in different portions of the mass, in a comparatively few weeks persons who have suffered for years from this distressing affliction are enabled to once more lead active lives, without the fear of this accident overtaking them. In this connection I cannot refrain from citing the case of a physician, known to several of those present. He had, for ten years or more, been in failing health, and at every act of defecation his bowel would protrude for several inches, accompanied by profuse hæmorrhages, which depleted him until he looked like a walking ghost, and many of his

professional friends had remarked: "Poor fellow! his days are numbered!" Two surgeons had refused to operate on him on account of his bad general condition. After about six treatments, as above outlined, given two years ago, his health had so improved that he satisfactorily passed a life insurance examination, and has gained some fifteen pounds, and once more enjoys life as he had not done for years.

His satisfaction, indeed, was so great that he came to me with the request that I would give him full information and instruction as to the method I used, as he thought it was such a wonderful power for good that he proposed to advertise and build up a business in the orthodox manner of the advertising "Rectal Specialist," which it is unnecessary to say I kindly but firmly declined to do under the circumstances. In the prolapsus of infants I always assure myself that *phymosis* does not exist, and, if found, remove it, as it is a prolific cause of prolapse.

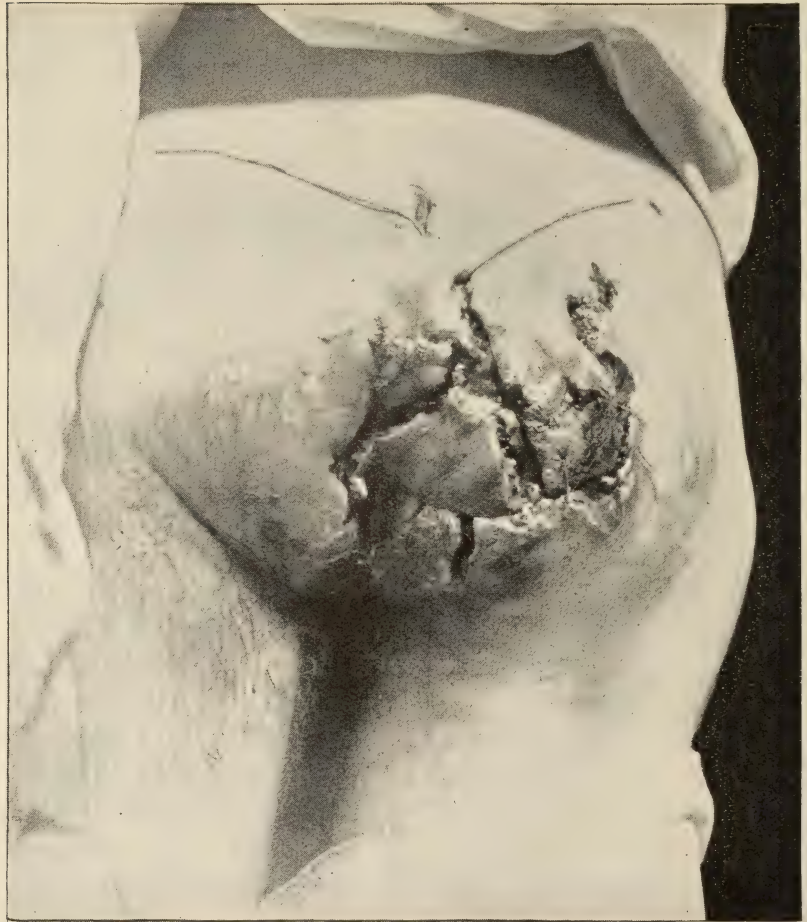
Rectal Abscess.—Nature is often kinder to us than the doctor, as some cases of ischio-rectal abscess are allowed to progress, and pus to accumulate and burrow, because the attending physician dislikes to make the necessary incision to allow of the escape of accumulated pus. One of my professional friends told me of the days of suffering to which he had been subjected, before he became a doctor, by his physician insisting that nature be allowed to cause the breaking of a rectal abscess. His tortures, he said, were indescribable for over a week; the buttocks were soggy and raw from the continuous application of poultices, and his nervous system shattered from loss of sleep and excessive pain, and each act of defecation caused him to become almost a maniac. Finally, in delirium, he rolled off the couch on which he had been lying for more than a week. The consequent succussion caused the rupture of the abscess, with the discharge of nearly a pint of the most fetid pus, and, strange to say, this man has no fistulæ. Now the plan I follow in these cases of ischio-rectal abscess is: As soon as the diagnosis is clear, without waiting for superficial fluctuations, I administer an anæsthetic, make the necessary incision to reach the collection of pus, and sometimes with the finger, at others using the curette, remove all sloughing tissue, dilate the sphincter, thus affording rest for the parts, and

materially thereby aiding in the consequent rapid healing; pack the cavity lightly to the bottom, cleansing the wound and changing the dressing daily, or as required. In my hands this mode of treatment leaves nothing to be desired, and I cannot now recall a single fistula following this method of treatment, when I have seen the case in anything like a reasonable time. Indeed, I have been surprised to see the rapidity of cure in some severe cases following the above method. Of course, in many cases of ischio-rectal abscess, a perforation of the bowel is the starting-point, but even here great results may be secured.

Rectal Fistulæ.—In the treatment of this affliction much may be accomplished by the exercise of patience, in conjunction with thorough cleansing, and the injection of various solutions by means of a specially constructed syringe having a silver canula about five inches long. The solutions which have given me the most satisfactory results are iodine tincture, a 10 per cent. solution of phosphoric acid, solutions of bromine, nitrate of silver, or of phenic acid, and often of pure bovine. Only a few days ago a lady from Cape May, N. J., called on me to again express her satisfaction at the result of treatment for a fistula which had existed some seven years, and which I had cured for her over three years ago by this method of treatment in about as many weeks as she had suffered years, and without any pain whatever being manifested, and without any confinement to the house. It would hardly be reasonable to expect this line of treatment to cure cases presenting numerous fistulous openings, or the horseshoe variety of fistula. In such cases my practice is to lay open all fistulous tracts until the main tract is found, and follow this up to the sphincter muscle, beyond which point I curette the sinus thoroughly; and if an internal opening can be found, I *excise the borders of this opening* and stitch them together, and then lightly pack the canal beneath, until it heals by granulation from the bottom. The stoppage of the draining from the rectum into the sinus by attention to the internal opening is the particular feature of this method, and will often save the necessity of division of the sphincter muscle, with its consequent risk of rectal incontinence; but cases are met with in which nothing short of severing the sphincter would hold out reasonable hope of successful

treatment. In such cases only one cut of the muscle should ever be made at one time, as nothing is more haunting to the rectal surgeon than a case of rectal incontinence; and yet even in these desperate cases surprising results may be obtained by great care, with a thorough understanding of just what to do.

In this connection I would like to cite a case to which I was



called by a brother physician last fall; it was a man 32 years old, who had been suffering for eight years with gluteal abscesses so numerous and so extensive that his whole buttocks presented an exquisitely sensitive and suppurating mass, accompanied by excessive and continuous pain, which existed night and day and prevented sleep, and it was altogether impossible for him to sit on the affected area, while pus discharged

freely, and, indeed, in large quantities from ten different openings situated in adjacent points over the entire gluteal area on both sides, but principally on the right. It was believed to be a case of tuberculosis and probably incurable. I have some photographs taken two days after the operation, which will in some manner show the enormous area occupied by this pyogenic and burrowed-out series of fistulous sinuses and cavities, and the extensive work required to have a reasonable hope of effecting a cure. At first sight the appearance of this case was most formidable. I was not sure myself, on account of its extensive ramifications, that it was not tuberculous in its origin. On account of the extreme sensitiveness of all the parts examination was extremely unsatisfactory, but it was obviously necessary to reconstruct the whole gluteal region in order to effect anything approaching a cure.

Under anæsthesia I laid open all these radiatory sinuses and pockets, some under the skin and others much deeper, and found them connected with a central cavity adjacent to the side of the bowel. This central cavity formed a deep sinus extending up alongside the bowel to a depth of four inches or more, and as large as my finger, but it was impossible to find any connection between this sinus and the interior of the bowel, although it was obviously a true fistula. When this part of the operation was completed, and the sinuses all thoroughly curetted, I packed the deep sinus with gauze and sutured the flaps, previously having removed with the scissors and curette all dead and pyogenic tissue,* then applied an antiseptic dressing snugly to support the flaps, and kept the deep sinus open by means of a drainage tube; the patient slept twelve hours the night following this operation. The cure was necessarily protracted, but the process was continuous and gratifying, and I am able to report now that the patient is substantially well and has been fulfilling a responsible position for the past five months, calling at my office occasionally for dressing. A couple of superficial sinuses remote from the original seat of trouble and of no particular significance, which can be laid open at any time, are now the only evidences of suppuration which he pre-

* This illustration (taken two days after the operation) will give a general idea of the extensive work necessary to remove the dead tissue and open the numerous fistulous openings to have the parts in the best condition for healing.

sents; he can now sit on his buttocks, and in fact to all intents and purposes is a well man. The portions from which large areas of flesh were removed having cicatrized very kindly, the result has been surprisingly good.

I have in these remarks laid little or no stress on the internal administration of remedies, but this is not because I have no confidence in internal medication in these cases, but because most of the cases to which I have referred have been placed under my care by other physicians, who were quite as well skilled in the treatment of these affections by medication as myself, and in some instances much more so, and also because the subsequent treatment, so far as internal medication was concerned, was necessarily in the hands of those physicians in conjunction with whom I operated, and upon whose province I have made it an inflexible rule not to trench, either in my professional consultations with them or in my intercourse with the families into which I have been called in connection with these matters.

BARLOW'S DISEASE.

BY MILLIE J. CHAPMAN, M.D., PITTSBURGH, PA.

(Read before the Homœopathic Medical Society, State of Pennsylvania, Pittsburgh, Sept., 1898.)

It is now twenty years since Cheadle, of London, called attention to cases of scurvy among infants and children supervening on rickets. Barlow described the anatomical conditions as determined by autopsies, and a generous profession at once rewarded his scientific efforts by classing the partnership of scurvy and rickets as Barlow's disease. England furnishes the greatest number of cases reported and the most literature upon the subject. In 1894, Huebner stated that outside of England only fifty cases had been observed in the past thirty years; fifteen of those were American. Since then Rotch reports that he has treated seventy cases; another author twenty; several others three or four each. Doubtless the added list reported is due to a more careful observation rather than an increase of this form of disease. It is supposed to be of chemical origin, due to the persistent deprivation of fresh

food. It is not surprising that many adults in the Klondike fields to-day are suffering from scurvy, the environment contributing to this condition. But infants are afflicted with a similar disease, whether blessed with princely surroundings or dwelling in the haunts of poverty, if deprived of the natural food and sustained for a prolonged term upon some of the many canned, condensed, baked, boiled, powdered, malted, or otherwise manufactured articles. Our zeal to combat microbes and bacilli by administering milk only after it has been pasteurized, sterilized or diluted, has no doubt been an element in the development of this morbid state.

Most cases occur between six months and two years of age. The various authors agree upon the characteristics of the disease, viz.: marked anæmia, tendency to ecchymosis about the eyes, œdema of the upper eyelids, swelling and sponginess of the gums when teeth are present; purpuric spots on limbs; hæmaturia and intestinal hæmorrhage; a predominance of lower-limb affection; immobility, going on to pseudo-paralysis; excessive tenderness; swelling; skin shiny and tense but seldom pitting; no undue local heat; thickening of the shafts of bones, due to subperiosteal hæmorrhage; liability to fracture near the epiphyses. A child who has seemed well gradually becomes pale, wasted, irritable, and manifests pain on handling; excessive tenderness of the lower limbs when moved at all; the child constantly moaning or screaming with agony. These symptoms have been mistaken for rheumatism, and in one case for injury of the spine, and was treated with a plaster jacket and other accessories of the heroic school. The child had been fed on malted milk ten months, pasteurized cream added later a portion of the time, and had been given until it learned to call for the beverage of its nurse. Green tea—the English reports ascribe the use of tea among the causes of scurvy. The reports of those treating the largest number prove that the most aggravated cases rapidly improve upon a change of diet in which the list includes fresh milk, meat, vegetables or fruit-juices. No doubt all cases would be avoided if the diet was varied sooner. Since there are so large a number of children bottle-fed and thus liable to this disease, which if not wisely treated gradually proves fatal, it is of the greatest importance that all nurses and mothers be instructed that children deprived

of the natural food should be given fruit or vegetable elements as a prophylactic of scurvy. After the prepared foods have been given until a child is four months old, a spoonful of grape-juice added to the bottle once a day, bovine—or, better, freshly prepared meat-juice—will counteract this tendency, never forgetting to give cold water to drink. The English add sieved mashed potatoes. I have used a spoonful of baked potatoes, sieved, in the bottle of milk once a day, for thin, scrawny children, and found prompt relief. In winter, when fruits are not always available, the following has been of great service: One potato, an onion, a turnip, all pared, put in two quarts of water, boiled until the potato falls apart; strain, salt, and add an ounce to the bottle each feeding. One well-developed case rapidly improved by use of ripe elderberry juice. Children who have teeth and are able to chew profit by use of celery or cabbage. The Old School depend wholly upon corrected diet and good nursing, but we are able to see health sooner and more permanently established by the administration of our well-indicated remedies. A study of each case will find a similar in one of the following: Carbo veg., ars. alb., calcarea carb., calc. phos., phos. acid, mercury, lil., agave Americana; and in one case, where the subperiosteal hæmorrhage of the femur was considerable, the continued use of arnica 6x was attended with the happiest result.

SEMINAL VESICULITIS.*

BY LEON T. ASHCRAFT, A.M., M.D., PHILADELPHIA,

Lecturer on Venereal Diseases at Hahnemann Medical College; Senior Surgeon,
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DISEASE of the seminal vesicles may arise from gonorrhœa, tuberculosis, and simple, non-specific inflammation. The majority of cases may be attributed either directly or indirectly to gonorrhœa. Because of this fact, my remarks will be directed chiefly to that type.

* Read before the Homœopathic Medical Society of the State of Pennsylvania, Pittsburgh, Pa., September 27, 1898.

Seminal vesiculitis has received very little notice from American writers, Fuller, Taylor and Thorndike constituting the notable exceptions. The seminal vesicles are two lobulated, membranous pouches situated at the base of the bladder and in front of the rectum. They are separated from the latter organ by the recto-vesical fascia. Each vesicle measures about two inches in length, three-fourths of an inch in breadth, and about one-half of an inch in thickness. They lie imbedded in the filaments which branch off from the fibrous bands, extending from the posterior surface of the prostate to the walls of the bladder. Although separated at their upper surface, they converge towards the base of the prostate, and end in a duct which joins the corresponding vas deferens at an angle, forming the ejaculatory duct. These ejaculatory ducts enter the prostate at its base, pass through it and enter the prostatic urethra either on the sides of the sinus pularis or within this cavity. In some instances the peritonæum is reflected over the upper surface of each vesicle. Each pouch consists of a main cavity, with various-sized diverticula; all are joined by fibrous tissue. They have an external covering, which is fibro-cellular, a middle muscular coat and a lining mucous membrane; columnar and cuboidal epithelium line the vesicles. The vas deferens runs along their inner margin. The middle and inferior vesical and middle hemorrhoidal trunks furnish their arterial and venous supply. Their nerves are obtained from the pelvic plexus.

The seminal vesicles furnish a storehouse for the semen, preserving its vitality by furnishing a secretion obtained from their epithelial lining, and retaining it until called upon to expel it.

Gonorrhœa causes tissue changes not only in the vesical walls, but also occasionally in the spaces between and about them, producing a peri-vesiculitis. Both vesicles are usually attacked, causing alterations in their chambers, their secretions, as well as their contents. The ejaculatory ducts are usually involved, and in some instances the prostate participates in the morbid process. Fuller apparently ignores prostatic inflammation as a complication. That he is in error is readily seen by recalling how intimately the prostate and vesicles are connected through the agency of the ejaculatory ducts.

Acute gonorrhœal seminal vesiculitis causes swelling of the mucous membrane and small-cell thickening in the submucous connective tissue. The vesicles may be dilated or become atrophied by contraction of the newly-formed tissue. Their contents undergo a puriform degeneration. Microscopical examination shows dead spermatozoa. Chronic seminal vesiculitis commences insidiously. Symptoms are rarely complained of until months after an attack of gonorrhœa. The process consists of an inflammation of the mucous membrane, with degeneration of the epithelium and subsequent catarrh. Later, this infiltrate extends into the entire substance of the vesicles, producing marked thickening in their walls, thus impairing their function. The semen is markedly affected, becoming semi-purulent and sometimes bloody, and frequently losing its normal consistency. Microscopical examination of the expressed secretion of the vesicles will show phosphates, mucus, synpexions (small particles resembling starch granules), and apparently dead spermatozoa. Occasionally pus, gonococci, tubercle bacilli and bacteria may be seen. The changes in the urine are characteristic. The first portion voided will be clear, except where gleet exists. The residue will be cloudy, particularly if pains be taken to express the vesicular contents. Chronic inflammation of the ejaculatory ducts may result in an atonic condition, which, associated with the changes just enumerated, will interfere with the ejaculatory act.

Acute seminal vesiculitis presents marked inflammatory symptoms. Pain is an annoying feature; it is usually referred either to the supra-pubic region or to the sacrum and rectum, and in those cases which are complicated by epididymitis pains may extend from the perinæum and scrotum to the inner aspect of the thighs. The temperature rises to about 103° F. The bowels become confined and the tongue is heavily furred. The urethral discharge is suppressed, remaining so until vesicular resolution occurs. Bloody pollutions, caused by capillary hæmorrhage, may occasion alarm. The urinary changes are quite characteristic in the beginning of an attack, differing but little from the urine as seen in acute gonorrhœa, except that urination may be more frequent. Later on, when resolution is established and the vesicles empty their contents, it becomes decidedly clouded. The disease arises by extension from the

posterior urethra, and may usually be traced to imperfect instrumentation, particularly while practicing urethral irrigation. Fortunately, most cases end in resolution, although exceptionally an abscess forms, which bursts into the peritonæum or the rectum. Many of these symptoms may accompany posterior urethritis and acute prostatitis. Any doubt as to the precise nature of the case will be dispelled by making a thorough rectal examination. The examining finger will usually detect two swollen bodies situated somewhat above the prostate. The symptoms present in the chronic type point directly to interference with the sexual function. In mild cases sexual erection is an annoying feature, while feeble erection and lost desire are present in advanced subjects. Coitus, if practiced, lacks pleasure, the ejaculatory act being precipitate or tardy, and sometimes very painful.

Seminal losses constitute a very annoying and persistent feature. Nightly pollutions are frequent, occurring even after sexual indulgence. The normal color of the semen is changed to a brown or dull red shade. This is frequently observed in those cases which are complicated by tuberculosis. An intermittent urethral discharge may accompany seminal vesiculitis, and although it is a popular professional belief, which I share, that almost all chronic urethral discharges may be attributed to a stricture of large calibre,* nevertheless my experience accords with others who have cured chronic urethritis by directing their treatment entirely to the seminal vesicles. Neurotic symptoms, both local and reflex, are quite pronounced; some complain of burning in certain urethral areas; others of coldness and numbness of the sexual organs. Slowly other reflexes become involved; the stomach and the brain are functionally affected, dyspepsia, impaired appetite, dimness of vision, headache and ringing in the ears are pronounced symptoms. As the condition progresses they become despondent, avoid society, and sink into a markedly neurasthenic state. This will be appreciated by recognizing how lost tone in a certain part of the sympathetic system produces a similar condition in other parts.

It must not be understood that these symptoms are present

* *Diagnosis and Treatment of Urethral Stricture of Large Calibre*, by Leon T. Ashcraft, A.M., M.D., *HAHNEMANNIAN MONTHLY*, March, 1898.

in every case, different grades being encountered; indeed, the disease may exist without causing reflex symptoms; and, too, in neurotic individuals the suggestion of sexual disorders may provoke a wealth of complaints. The local-tissue changes can only be ascertained by making a rectal examination. The proper technique as suggested by Fuller* is as follows: "The patient presenting himself with a full bladder should, while standing with his knees straight, bend the body forward at right angles; then the operator should introduce the forefinger of one hand well into the rectum, with the fist of the other hand exercising firm counter-pressure over the pubes." By these means the body of the vesicles may be felt; their contents may be expressed by firm pressure along the line of the vesicle. Occasionally the examination is attended with difficulty, particularly in men who have a protuberant abdomen and rigid perinæum. The normal vesicles should impart a sensation of elasticity; when diseased they are firm, hard and distended; the spaces between them may be swollen, or because of lost tone the vesicular walls may be relaxed. Pressure upon inflamed vesicles causes a sharp, sickening pain, and a flow of pus from the urethra. No rectal examination is completed unless the condition of the prostate has been noted. Frequently pressure on this organ is accompanied by a sharp pain in the region of the ejaculatory duct.

Chronic gonorrhœal seminal vesiculitis must be distinguished from chronic inflammation of the bladder, the prostate and the posterior urethra, and occasionally from urethral stricture of large calibre. Changes in the bladder and prostate produce symptoms directly associated with the urinary act. Chronic posterior urethritis may present the sexual symptoms observed in vesiculitis, but if present they are usually less conspicuous. Doubt may be set aside by making rectal exploration. Reference has been previously made to chronic vesiculitis, suggesting urethral stricture of large calibre. Finally, an inherited weakness of the sexual apparatus should not be mistaken for vesiculitis, nor should failure to perform coitus satisfactorily be attributed to these organs. It must be remembered that we occasionally meet with a psychical type of impotency.

* Fuller: *Disorders of the Male Sexual Organs.*

Before discussing the treatment, perhaps it would be wise to mention how seminal vesiculitis may be prevented. It has been shown that most cases arise by extension from the posterior urethra. Faulty technique, while practicing urethral irrigation, is largely responsible for posterior urethritis. Therefore, care should be exercised in diagnosing the location of urethral discharge. If it be confined to the anterior urethra, treatment should be directed solely to that region, and under no circumstances should vesical irrigation be practiced. Should a severe posterior urethritis complicate anterior inflammation, all local treatment must be interdicted until active symptoms subside.

During an acute attack, the patient should lie in bed and not be permitted to leave it until the inflammatory symptoms have subsided. He should lie preferably upon his back, and the scrotum should be firmly supported by a proper bandage. Constipation may be avoided by prescribing a mild laxative; the diet should be light and nourishing. Medicinally the best results are obtained from aconite, belladonna, pulsatilla and cantharis. It may be necessary, in cases of severe pain, to insert a rectal suppository containing a quarter of a grain of morphia. Should these measures fail to promote resolution and a rise of temperature associated with pelvic distress suggest abscess formation, evacuation will be indicated. This may be accomplished by administering an anæsthetic, introducing a rectal speculum and evacuating their contents.

The treatment of the chronic type differs materially from that of the acute stage. It has been pointed out that the most prominent symptoms refer directly to interference with the ejaculatory act. The restoration of this function, then, is the object to be achieved. This may be accomplished by *stripping* or *milking* the seminal vesicles, a method popularized by Fuller. To accomplish this the patient should be placed in the position necessary for examining the vesicles; moderate pressure should then be exerted upon these sacs. This is followed by decidedly beneficial results, since it serves to restore tone not only to the vesicles but also to the surrounding tissues. During this treatment the pathological material is expressed from the seminal vesicles; severe pressure should be avoided, since, in gravely diseased conditions, hæmorrhage may result or an acute inflammation may be set up. Following this act, the urethra and bladder

should be irrigated with a 1-2000 solution of permanganate of potash, thus freeing the urethra of the expressed contents of the vesicles, and possibly preventing bladder infection. This stripping process is in some instances followed by pain, both local and reflex. Subsequent treatments should not be repeated until after all inflammatory changes have disappeared; this takes about five days. The average period of time required to effect a cure may be placed at from five to six months; in some aggravated cases even longer. In pot-bellied individuals it is almost impossible to reach the seminal vesicles. In such cases I have obtained fair results from passing a full-sized rectal bougie. Where pronounced anæmia exists, it may be necessary to combine medicinal with local treatment. I have found strychnia phos., one one-hundredth of a grain, and phosphorus beneficial. Where tuberculosis complicates the condition, relief may only be obtained by surgical means. It must be remembered that such a procedure is rarely demanded in the gonorrhœal type. The surgical measures proposed are incision and removal; the former has been discussed. Removal is accomplished by following the course suggested by Kraaske. It consists of an incision beginning near the posterior superior spine of the ilium on the left side and extending along the body of the sacrum. The coccyx is enucleated, and the corresponding sacral wing resected. Should it be necessary to remove both vesicles, a similar incision should be made in the opposite side. This exposes not only the vesicles, but also the prostate and the base of the bladder. Fortunately this operation is rarely demanded, mechanical means usually sufficing to produce a cure.

THE HASTENING OF LABOR BY INTRA-UTERINE RUBBER DILATORS.—Graefe recommends their use. In thirty-four out of thirty-eight women the parturient canal was dilated in from one-quarter to six hours, so that the child was delivered spontaneously after expulsion of the kolpeurynter or could be extracted by forceps or version. Three of the women died, but not in consequence of the operation. Only two of the patients suffered from mild puerperal diseases. Thirty-two out of thirty-nine children were born alive. It has been valuable especially in eclampsia and placenta prævia.

EDITORIAL.

WM. H. BIGLER, A.M., M.D.

WM. W. VAN BAUN, M.D.

THE NEURON.

THE application of the neuron conception of the nervous system to the explanation of some of the hitherto inexplicable phenomena of disease and of consciousness forms one of the most interesting subjects of study. Let us briefly indicate some of the directions in which this conception may prove of service, after having briefly stated the outlines of the views in regard to the neurons.

The physiological unit of the nervous system is the neuron, consisting of the nerve-cell with contained nucleus, and its various outgrowths, the dendrons or dendrites, which form the channel through which impressions are brought to bear upon the nerve-cell, and the neuraxon and its collaterals, through which impulses are sent out centrifugally from the nerve-cell.

The numberless units of which the whole system is composed stand to each other in adult life in the relation of contiguity, not continuity, while during the period of fœtal development, before the growth of their several prolongations, they were not fixed in position, but were capable of amœboid movements, and hence their final location and histological environment have been subject to modification from without as well as from within.

The part of the cell from which the neuraxon is to grow, and therefore the direction in which it is to enter into communication with contiguous cells, seems in each case to be determined as an hereditary predisposition, and yet variations may occur whereby abnormal connections are established and abnormal responses elicited.

The fact that each cell has as many pathways for impressions to reach it as it has dendrites, and as many routes for impulses to leave it as it has collaterals and neuraxons, shows that from a purely anatomical or histological standpoint the response to stimuli from without is originally indeterminate, and that the actual responses, as we find them now, have been determined by other factors. These factors are heredity, environment,

habit and education. In the lowest forms of nervous systems we find the response to stimuli simple and direct, determined according to the principle of self-preservation. Corresponding to the more complicated relations which higher organisms bear to their surroundings, a more complex organization of the nervous system is developed by the growth of dendrites and collaterals. Many new possible pathways for incoming and outgoing impulses are thus opened, but one comes from frequent use to offer a route of least resistance, and thus eventually remains fixed as the so-called normal one. As like begets like, this character of response is handed down from generation to generation and becomes hereditary.

It is evident that during the development of the complexity of the nervous system, before the dendrites and collaterals have become fixed in their hereditary connections, conditions may arise which may cause a disarrangement of the elements and lay the foundation of gross departures from hereditary characteristics, or even lead to absolutely abnormal manifestations. Such results are seen in the case of congenital idiots, and in the dispositions of single children, out of a large family, marked by peculiarities clearly traceable to the environment of the mother during pregnancy.

It will be seen that under the phrase "response to stimuli" we include also those responses in the higher centres which are accompanied by phenomena of consciousness, viz., emotions and volitions, the sum of which constitute character. The value of training during the formative period of the growth of the individual, with special reference to this physical basis of character, cannot be overestimated. Training is too often made to lie in seeking to develop a morality which, as taught, has no basis in nature, and which, therefore, never becomes an integral part of character. By using the receptive nervous system as the starting-point of a series of impulses which are constantly made to lead to noble thoughts and unselfish actions, a *habit* of morality and virtue can be formed which will prove to be reliable if not, perhaps, very exalted according to the usual ethical standard of unnatural self-denial.

These views hold out the only hope for the correction of hereditary vicious tendencies. If training can be commenced before the vicious route has been established, while it is only a predisposition, a new pathway leading to better things can be

opened and confirmed, and there will be no danger of subsequent aberrations from the path of virtue. Many of the puzzling phenomena of insanity and of double consciousness find in this conception of the manifold lines of connection between the neurons a simple and easy explanation. The Ego, isolated from all connection with the external world except through the medium of the nervous system, constructs gradually for itself out of the mass of habitual nervous impressions and responses that which we call consciousness, which latter is dependent both for its existence and for its manifestation upon the persistence of the normal "response to stimuli," as above defined. A shrinking or alteration of the nervous elements from disease, or a violent displacement by trauma, is sufficient to establish abnormal connections, and to lead to abnormal responses, *i.e.*, to abolish consciousness for a time, and finally to give rise to a new consciousness constructed out of the new set of responses.

The protean symptoms of neurasthenia will readily be understood as depending upon the shrinking of the neurons as the result of overfatigue and exhaustion, and the consequent establishment of new relations and unwonted responses.

In the same manner the phenomena of partial insanity and idiosyncrasies find here their ready solution.

Even in the case of so-called functional disease, it does not require too great a stretch of the scientific imagination to suppose that the microscope fails to reveal pathological changes only because we have no absolute standard with which to compare the positions and relations of the various nervous elements concerned in the production of the symptoms. An abnormal or even a normal stimulus, if too intense, has produced such a disarrangement of the neurons along its usual route that an entirely new set of responses follow, and these, being in this sense abnormal, are regarded as indicative of disease, although neither caused nor accompanied by discoverable pathological changes as at present understood.

Neither time nor space allow us to dwell more in detail upon these various subjects, nor even to enumerate all the various phenomena of consciousness which find in this conception of the neuron their easy and complete explanation, but enough has been said, we think, to show its vast importance in lines of thought, non-medical as well as medical.

COUNCILMANIC NEURONS.

APROPOS of neurons, it would be a nice problem for those who are interested in the subject to find out the condition of the neurons presumably present in those Councilmen in Philadelphia who obstruct all measures looking to a supply of pure water to its citizens, in face of the epidemic of typhoid fever, demonstrably due to the execrable fluid at present distributed as water.

We might reason that the sight of the filthy fluid sets up a train of nervous impressions along a course of neurons whose connections have not been modified by environment, so that it gives rise only to feelings of pleasure excited by dim reminiscences of ancestral mud.

Or we might suppose that the pathways between the sight of water and the ideas of drinking and of bathing have never been developed by habit or education, so that the appearance of the aqueous extract of sewage and cemeteries fails to arouse the emotions of disgust which seem so natural a response on the part of well-regulated neurons.

Or, again, we might argue that they have been bitten by a "water snake," as a result of which their neurons have become so crenated and distorted that the impression made by the sight of the water only causes a responsive desire for fishes, and the loaves which proverbially accompany them.

Or, finally, it may be that the connections between sense-impressions and the higher intellectual centres have been neglected, so that the tables of statistics and reports of the Board of Health fail to make connection with their brains, and do not lead to the conclusions as to the cause of the epidemic which seem inevitable to the educated neuron.

In whatever way we seek to explain their remarkable apathy or obstinate obstruction, we fear that nothing but a rude shock, such as would be caused by the entrance into their homes of typhoid fever, with death in its train, would be able so to disarrange their neurons as to make them conform in their activities to what is regarded by the majority of lay and medical minds as normal and rational.

GLEANINGS.

DIAGNOSIS OF PULMONARY TUBERCULOSIS, PARTICULARLY IN CHLOROTIC SUBJECTS.—Dr. Papillon treats of that form of tuberculosis where in its being so little advanced there are no perceptible stethoscopic signs, and the disease manifests itself only in chloro-anæmia. During the past three years he has observed numerous cases of chloro-anæmia where tuberculosis was suspected or present under anæmia as a mask, and where valuable diagnostic signs were furnished by the pulse, the respiratory capacity and the arterial pressure. Every case of chloro-anæmia should be regarded as on the verge of becoming tuberculous if the weight of the body in hectograms in relation to the height in centigrams is below three; if the respiratory capacity, measured by the spirometer, is, for a moderate-sized person, less than three litres, then two litres in a small person.

Normally, the rate of the pulse is influenced by position, while in initial tuberculosis it is but little affected, whether the subject be standing, sitting or lying. If one be examined outside of the times following meals, this is only noted at the commencement of tuberculosis of the lungs.

Another peculiar feature of latent tuberculosis is the fugitive character of the pulse; it appears like a shock rather than a beat. But the most characteristic symptom which has until now been neglected is the low blood-pressure. Instead of 15–18 cms. of mercury it is constantly below 13–12, and sometimes even below 10. The toxine of the disease, as experiments with tuberculin have demonstrated, is the cause of this, it bringing about a cardio-vascular atony. Therefore, when in a chloro-anæmic subject the arterial pressure in the radial is below thirteen centimetres of mercury, the patient may be regarded as tuberculous, if one can exclude abdominal reflexes as those of the gastro-intestinal tract and coitus.—*La Settimana Medica*, Anno lii., No. 3.

BRACHIALGIA AND BRACHIAL NEURALGIA.—Prof. Oppenheim, of Berlin, has studied this question, for out of 189 cases of violent pains which were localized in the arms alone he found in fifteen a vertebral or a spinal disease; in thirty a pronounced neuritis, among which were six cases of grippe, twenty-two cases of true neuralgia as associated with diabetes, arthritis, heart disease and acute maladies, and in nineteen professional neuralgias. In ninety-six there were only “pains in the arms,” which pains did not follow any nerve-paths, and a search for points of pressure gave uncertain results. Here there is no actual neuralgia, but an affection which develops upon a “neuropathic” diathesis. Such pains are not neuralgias, but psychialgias, and along with them one will notice nervous or psychic symptoms, associated most frequently with neurasthenia, melancholia or hypochondria. The pains remit and exacerbate along with the general condition. These pains are provoked by any unimportant cause, as attempting to hold a pencil in the hand. The treatment also confirms the psychic base, for anything that acts on the fundamental con-

dition affects the pains. Electric baths, hypnosis, application of the X-rays, etc., will bring about improvement.—*Hospitalstidende*, No. 40, 1898.

DISTURBANCES OF THE NERVOUS SYSTEM IN MALARIAL INFECTION.—Dr. Enrico Bardellini states that in examining and classifying the nervous disturbances and alterations from malarial infection one should not neglect examination of the blood, nor confuse matters by attributing to the infection those changes brought about by the salts of quinine. He divides these alterations as follows :

Brain Symptoms.—Headache.—This should be distinguished from that of the attack where it appears to be due to the thermic elevation, for this former is a culminating sign of grave malarial infection, and it does not disappear even when the disease seems to have been combated fully.

Delirium.—Mild and fugacious in slight cases ; in the grave it often dominates the whole clinical picture, whence those pernicious forms called pernicious delirient or phrenitic.

Sopor and coma, the latter a graver form of the former, are very frequent in severe cases. Galen and Lomnius have recorded such cases.

Hemiplegia and aphasia are rare, if one considers the number of individuals yearly attacked, yet they are not infrequent. They may be transitory, or follow in one attack after the other. Monoparesis has been described.

Convulsive phenomena may be : epileptiform or eclamptic, tetanic, choreic or athetotic movements ; tremor. Those of the first two groups are seen in severe forms of malaria, while those of the third and fourth are noted in cachectic and debilitated subjects after numerous febrile attacks.

Bulbar Symptoms.—These consist chiefly of dysarthria, paralysis of one or both facial nerves, of the hypoglossus or of hemianalgesia, etc.

Spinal Symptoms.—Malarial paraplegia and paralysis of the rectum and bladder have been observed. These cases are doubtful, however.

DISTURBANCES OF THE SYMPATHETIC NERVE.—These consist essentially of vaso-motor phenomena, as hyperidrosis.

Peripheral Nervous System.—Neuralgia and neuritis. The former often acts as a substitute for the febrile attack, and is characterized by its intermittency. The trigeminus is preferably affected in its first branch, but the literature presents cases of intermittent oophoralgia, otalgia and cystalgia.

Neuritis is not frequent ; it may be isolated or general.

DISTURBANCES OF THE SENSES.—Disturbances of vision are frequent in the literature, but those of the other senses are rare. The eye-changes range from amblyopia to amaurosis. The ophthalmoscope has revealed hæmorrhages into the retina in the region of the papilla, or in the small vessels numerous leucocytes bearing pigment are detected.

Mental Disturbances.—Lejonne has demonstrated that malaria may cause three nervous and mental affections : hysteria, neurasthenia and hysteroneurasthenia, which may persist even after the infection has been gotten under control. Dr. Triantaphylides in studying malarial neurasthenia has observed it to differ from the ordinary form in that it has a certain periodicity, and is advantageously treated by salts of quinine. But the writer warns against confusing hysteria or neurasthenia where malarial infection has been contracted later. Here the nervous or mental affection is not the result. Look to the previous history of the patient.

Psychic Complications.—Rare, though there yet be a palustral mania as well as a malarial paranoia, as has been recorded. In general intact, the minds of malarial patients may be indifferent to apathetic.

Special Symptoms.—Complex nervous syndromata have been noted after infection, as those simulating locomotor ataxia, disseminated sclerosis, paralysis agitans, Dubini's disease, as well as that described by Flaiani.—*Annali di Medicina Navale*, fasc. ix-x., 1898.

THE PERIOD OF INCUBATION OF TYPHOID FEVER.—Dr. Janchen states that immediately after the fall manœuvres of the Austrian troops, in one regiment of infantry there broke out thirty-six cases of typhoid fever. The disease set in suddenly, without prodromal symptoms, with fever, diarrhœa and malaise. In seventeen cases there was an eruption, in twenty-three a distinct enlargement of the spleen. The disease was tolerably short-lasting, in that they all had defervesced in three weeks. The soldiers had been three weeks at the manœuvres, and were till then well. On the home march they took different ways. The Seventh Infantry, on a warm day, rested in a village country where there were typhoid cases, and drank copiously of water brought by the country people in jugs and pitchers. Already in two days there were three sick with the disease; on the third day, seven men; on the fourth day, six men; on the fifth day, four men; on the sixth day, four men; on the seventh day, five men; on the ninth day, one man; on the tenth day, two men; on the eleventh day, one man; on the twelfth day, one man; on the thirteenth day, one man, and on the fourteenth day one man. In general, it is assumed that the period of incubation varies from two to three weeks. In these cases the source of infection could be definitely determined. Hence it follows that the incubation period may be very short—in fact, not longer than forty-eight hours at times.—*Norsk Magazin for Lægevidenskaben*, No. 10, 1898.

A STUDY OF INTERSTITIAL NEPHRITIS DIAGNOSTICALLY.—Dr. Brown directs attention to the frequency with which interstitial nephritis develops latently. Though a cure is not to be hoped for, yet much may be done by hygiene and diet to prolong life. If there be neither albuminuria nor cylindruria (casts), a diagnosis may be made by:

1. Polyuria, with diminution of density.
2. Decrease of the urea excreted.
3. Cardiac hypertrophy, without a valvular disease and with increase of the pulse tension.

4. Various nervous symptoms: headache, vertigo, insomnia and dyspnœa.

One should always examine the urine carefully in old persons with: getting up at night to urinate, a non-explainable weakness of other organs.

1. Flatulent dyspepsia or diarrhœa without apparent cause, violent and spasmodic vomiting, repeated bilious attacks. 2. Dyspnœa, asthma, chronic bronchitis. 3. Repeated headaches, and especially if occipital; persistent neuralgias, vertigo and insomnia. 4. Over-tension of the heart-stroke or artery (radial) or visible beating in any part of the body. 5. Severe hæmorrhages from the nose or stomach. 6. Diminution of visual powers, a sudden deafness or roaring in the ears. 7. Coma, convulsions, muscular tremors, mental confusion, apoplexy.—*La Settimana Medica*, No. 42, 1898.

To these latter might be added a number of others: for example, an over-

powering tiredness after the least exertion; "too tired to talk;" a slow recovery from any simple infectious disease or inflammation; the knowledge that the patient is addicted to morphine or opium in any form, as well as alcohol, or that he has been taking sulphonal for a long time; persistent neuralgiform attacks of pain in the legs; a leaden paleness of the complexion; chronic rheumatoid pains; a steady loss of flesh without seeming cause. Morphine will bring about a chronic interstitial nephritis if continued habitually for a long time. Such patients will bear acute diseases badly.

THE FUNCTIONS OF THE KIDNEYS IN DIABETES.—Dr. G. Mascarel states that the kidneys of diabetics may present lesions not due to the original disease, as fatty embolism, amyloid degeneration, abscesses and tubercles, interstitial nephritis, and particularly the parenchymatous form, as well as the special changes of diabetes itself—hypertrophy and cellular necrosis. Albuminuria is a very frequent complication of the affection: it may be either benign or severe—functional or dependent on a renal lesion. Glycosuria and glycaemia are not necessarily proportional. A mild degree of glycosuria may be present with an extreme glycaemia, a fact due to imperfect renal filtration. The permeability of the kidney is of prime importance in the prognosis. Here the test with methyl-blue is useful (Achard and Castaigne). In making tests with foods, it should be determined that non-elimination of sugar is not due to abnormal renal conditions.—*Revue Générale de Pathologie Interne*, No. 17, 1898.

A CASE OF A PULSATING DIVERTICLE OF THE ŒSOPHAGUS.—Dr. Henry T. Butlin elicited the characteristic symptoms—regurgitation of undigested fragments of food several hours after their ingestion, a sense of pressure in the posterior cervical triangle, detection by examination with the œsophageal sound, and general emaciation. Several writers, as Bergmann, Billroth, Kocher, Bayer and Mixter, have recorded cases where pulsating œsophageal diverticles have been removed. Butlin himself has done this operation twice. The result in both was satisfactory and lasting. He advises before operating to introduce a curved metallic sound into the diverticle through the mouth, and to press it well outward into the posterior cervical triangle, that the presence of the sac be demonstrated with certainty. Before operating, attempt to exclude any stricture of the œsophagus.—*Wiener Medizinische Presse*, No. 42, 1898.

EXAMINATION OF THE URINE FOR TUBERCLE BACILLI AND ITS DIAGNOSTIC VALUE.—Dr. Williamson says that whenever the urine contains pus and the cause is unknown one should examine for tubercle bacilli. The presence of the germs in small caseous masses even in urine not containing pus or blood, even though there be no subjective symptoms, will render a diagnosis certain. He reports a case where general tuberculosis was thus diagnosed. To avoid error in males from the smegma bacilli, if one obtain from the urinary sediment without any special precautions and stain according to Cabelt numerous red bacilli, then tuberculosis is almost certain. If the bacilli are arranged in groups or chains, tuberculosis is also present. But in other cases, and if an operative procedure be thought of, then the urine should be drawn with a catheter, in order to eliminate error from the smegma bacilli, as we know of no staining methods sufficiently accurate to distinguish them from those of tuberculosis.—*La Settimana Medica*, No. 10, 1898.

A CASE OF KAHLER'S DISEASE—ALBUMOSURIA.—Prof. Bozzolo had sent to him in 1893 a patient from London, with the diagnosis of nephritis. In 1891 he had had the grippe, when he had severe coryza, his sense of smell disappeared, and his hearing decreased greatly. Up to 1891 he had had a fixed pain in his right shoulder, in 1892 pains in the right flank, and in November, 1892, pains in the lumbar region. The urine was examined in 1892, and a great deal of albumin found. In the specimen seen by Prof. Bozzolo the condition was singular. It was extremely acid; on heating it 45-48 degrees an abundant whitish precipitate formed, which on increasing the heat to 55°, and on boiling, the urine cleared up. Cold acetic acid yielded no precipitate. Nitric acid did, however. Millon's reagent produced an abundant coagulum, which became reddish on heating.

The biuret reaction was present. With acetic acid and the ferro-cyanide of potash a goodly precipitate formed. This dissolved on heating. There were no true casts in the sediment. On account of these reactions he diagnosed albumosuria, and from that, in association with the bone pains, he diagnosed multiple myelomata of the bones, or Kahler's disease. The course confirmed the diagnosis. The patient died in 1896. He proposes to call the disease after Kahler, who first described it.—*La Settimana Medica*, No. 11, 1898.

Dr. H. T. Hanks, New York, in the *American Gynecological and Obstetrical Journal* for December, states that from a four years' experience with nosophen in his gynæcological practice, he believes it has virtues equal to those of iodoform, while it is odorless and should, therefore, supersede this objectionable-smelling drug, especially as it is not more expensive to use, because of its being so much more voluminous than iodoform. Nosophen is a pale and yellowish powder, containing about 60 per cent. iodine in chemical combination with phenolphthalein. He finds it to act perfectly well in preventing excessive and rapid suppuration in all abrasions and erosions of the cervix, and on all raw surfaces after curettement. He uses nosophen gauze for packing the uterine cavity after removing the *débris* of an abortion and after curetting her for causes, the gauze packing remaining sweet for three days in such cases. Also on abdominal wounds the gauze meets every indication of iodoform gauze.

FRANK H. PRITCHARD, M.D.

THE STERILIZATION OF INSTRUMENTS WITH FORMALDEHYD.—Reik, of Johns Hopkins University, reviews his experiments in formaldehyd sterilization, and summarizes his conclusions as follows:

(1.) A lamp will burn in any absolutely closed chamber long enough to generate more than sufficient formaldehyd for its disinfection.

(2.) In a chamber of one cubic foot space 5 grains of paraform will in 15 minutes accomplish disinfection.

(3.) The expense of such disinfection, including the cost of paraform and alcohol, will not exceed one cent, and the labor involved is almost nothing.

(4.) For the disinfection of small instruments, such as those used by ophthalmologists, laryngologists and dentists, it is by far the most convenient and speedy method.

(5.) This method carries out, probably better than any other designed for the work, the principles of disinfection—the absolutely certain destruction of all pathogenic organisms in the shortest possible time, at the least expense, and with a minimum of injury to the object of disinfection.—*Philadelphia Medical Journal*, February 4, 1899. F. MORTIMER LAWRENCE, M.D.

PERFORATING ULCER OF THE DUODENUM—OPERATION—RECOVERY.—Dr. Hugh M. Taylor, of Richmond, reports a case of this rare disease, with the happy result indicated in the caption. A 17 year old girl had experienced obscure abdominal pain for a week. Profound collapse came on after a full meal and brisk exercise, and was supposed to be due to a ruptured appendicial pus collection. Twelve hours after the acute symptoms commenced an incision was made as for appendicitis and the appendix delivered, when, to the surprise of all, it was found to be normal. The incision was continued downward and the pelvic viscera examined, but nothing found; then it was enlarged upward to the ninth costal cartilage and the bile tract examined. It, too, was found intact, but the perforation was quickly found in the duodenum. The opening was closed and the diphtheritic-like lymph wiped from the intestines, and the abdomen flushed with hot salt solution. The abdomen was packed, and some pus was found on the removal of the gauze a few days later; but the patient made a good, though slow, recovery.—*Virginia Medical Semi-Monthly*, January 27, 1899.

THE FREQUENCY OF VARICOCELE AND THE LIMITATIONS OF OPERATIVE TREATMENT FOR THIS AFFECTION.—Dr. N. Senn, of Chicago, says that for years he has been convinced that too many operations were being done for varicocele. Most of the persons suffering from this affection are sexual neurasthenics—young men who have made a deep study of this subject with the aid of quack literature. The size of the varicocele bears no relation to the degree of suffering and distress complained of by the patients. During May of last year Dr. Senn, as a member of the Examining Board, examined 9815 recruits for the volunteer service; 21.17 per cent. of all these had varicocele. Atrophy of the testicle was seldom noted. Even large varicoceles, with the exception of three or four cases, gave rise to no pain or discomfort. In more than half the cases the men were ignorant of the existence of the affection. If the surgeon can secure the full confidence of his patient, operation, as a rule, is unnecessary.—*Philadelphia Medical Journal*.

SUTURE AND LIGATURE MATERIALS.—Dr. Charles P. Noble, of Philadelphia, after detailing his experience with catgut, silkworm-gut and silk in abdominal work, concludes as follows: "For the expert who has every facility at his command which the modern hospital affords, I think there can be no question that the absorbable sutures and ligatures offer distinct advantages over the non-absorbable. For the occasional operator, I question very much whether this is true. He is not likely to have a supply of sterile catgut, nor the facilities to sterilize it. His relative inexperience also in applying ligatures puts him at a disadvantage in using catgut, as undoubtedly more skill and patience is required to properly secure catgut ligatures than silk ligatures. Therefore, except for the expert, I am inclined to believe that sterile silk will give better results than catgut."—*Medical News*.

PRESENT OPINIONS ABOUT APPENDICITIS.—Hard concretions are found in 12 per cent. of all cases operated upon for appendicitis. Hard or soft concretions, or both, are found in about 20 per cent. of operated cases. Mucous inclusions are found in more than 80 per cent. of operated cases in which the patient has had one or more acute attacks of appendicitis. Cases with hard or soft concretions or mucous inclusions are cases for recurrence of acute

attacks of appendicitis from time to time. None of these conditions are curable by medical treatment, though a large proportion of acute exacerbations are more or less amenable to medical treatment. No one can foretell when a mucous inclusion is to rupture or when a concretion is to escape through the appendix walls. The condition of the appendix proper cannot readily be determined before operation in acute cases. The condition of the appendix proper can usually be very satisfactorily determined by expert palpation in the interval between acute exacerbations.—DR. ROBERT T. MORRIS, in the *New England Medical Monthly*, January, 1899.

In a reprint at hand from Dr. Nathaniel W. Emerson (*New Eng. Med. Gazette*), he publishes a list of 102 operations for appendicitis, with three deaths. Attention is called to the fact that all the fatalities were in those in which pus was present. In all those which were taken during the interval, or in the midst of an acute attack before pus had formed, no death occurred. In this latter class convalescence is simple and rapid, the patient being frequently discharged in two weeks, and usually able to attend to ordinary duties within a month.

In the *New York Medical Times* for February Dr. John B. Deaver says: "We have lately made a report of our cases of appendicitis operated on in the hospital, and find that the percentage of mortality in all cases operated upon, favorable or unfavorable, is $7\frac{1}{2}$ per cent. In the acute cases the percentage is $19\frac{1}{2}$ per cent. As regards the chronic cases, we have now operated on 125 straight cases without a death. This favors the general idea that early operation is best. It may be said that it is no wonder that the mortality is so large in acute cases, because in every case we remove the appendix. In answer to this I say that the figures of as good an abdominal operator as there is in this country, which have been published lately, gives a mortality in similar cases of $22\frac{1}{2}$ per cent. He does not remove the appendix in all cases. This would still indicate its removal in all operations."

DRESSING FOR FRACTURE OF OS CALCIS.—A. M. Whiton, M.D., South Byron, New York, says: "Having looked in vain for specific directions in the treatment of a fracture of the 'heel' or os calcis, the following is submitted:

"A roller bandage three inches wide and five yards long is all that is necessary. Starting with two turns above the toes, the roller is carried diagonally over the instep covering the external malleolus, behind and below internal malleolus to sole of foot, pulling fragment down. Passing over outer side of foot diagonally across instep, covering internal malleolus, behind and below external malleolus to sole of foot again, dragging fragment down, but from opposite direction of the first turn. A repetition of these turns, as may be necessary, is all that is required to keep parts immobile until union takes place."

F. WALTER BRIERLY, M.D.

PUERPERAL FEVER (Olshausen).—Childbed fever is considered to-day as a wound infection originating in the genital tract of a lying-in woman, and we recognize that micro-organisms which have an injurious effect on the body belong to such infections besides the wounds which no puerperal patient escapes.

We differentiate, theoretically at least, infection and intoxication, and only speak of the former when the microbes penetrate the tissues and organs of

circulation, and of intoxication when the germs remain in the parturient canal and have an injurious effect solely by resorption of their toxins. It is reasonably certain that the dangerous varieties of the fission fungi, the streptococci and the staphylococci especially, penetrate the tissues; the excitors of decomposition, on the contrary, remain in the uterine cavity and cause merely resorption fever.

The question arises whether the name puerperal fever should be limited to diseases produced by streptococci and staphylococci. The reply must be decidedly negative. The acceptation generally held good until recently that streptococci and staphylococci introduced into the genital canal, and especially in the uterine cavity, always produced infection, has been refuted by exact observation and experiment, as well as by the opinion that the excitors of decomposition never cause infection. It is now recognized that the bacterium coli, the pneumococcus and other microbes invade the tissues of the genital tract in a frequency still unknown to us, and may lead to severe or even fatal diseases having local lesions just like those produced by the usual excitor of puerperal infection.

It is possible in some cases to ascertain the particular kind of microbe which has produced the disease, but this is seldom practicable on the living except in hospital practice, and often fails on account of the multiplicity of the flora of the genital tract. An attempt to define the disease according to the infecting organism would be impracticable, or rather impossible. We must be guided rather by the localization of the disease, its course and prognosis, according to the origin of infection.

The second question in the definition of childbed fever is the separation of infection in its narrower sense from intoxication. Such a separation at the present time is impossible. There may be many cases in which we may say at the autopsy an infection was present; but in the living, in the great majority of the mild forms of the disease, it is impossible to decide whether the microbes produced the symptoms of disease solely by the resorption of toxins formed in the genital canal or by the invasion of the tissues.

If such a distinction is made theoretically, and it depends on a correct interpretation of the facts, the pre-eminently injurious factor is the same in either case. The characteristic symptoms, as fever, alteration of general conditions, collapse and fatal termination, even in infection, are caused only by the resorption of ptomains. Only diseases of single organs belong exclusively to infection. A separation between intoxication and infection is impracticable and the less correct, as the final causes of both the diseases and the fatal termination are the same.

There is an infection of another kind which may originate in the genital tract of a puerperal patient and lead to a general disease of the most severe type, *i.e.*, tetanus, and yet be subject to the usual definition of puerperal fever. It is, however, a disease so specific in its ætiology, symptomatology, and runs such a characteristic course, that it scarcely can be mistaken for any other kind of an infection, and is not included in the term, "puerperal fever," though it corresponds to its definition.

Something similar might be said of scarlet fever. It is not improbable that the puerperal wound might be inoculated with the peculiar poison or infection of scarlet fever. This would explain, perhaps, some of the peculiarities

of scarlet fever in the puerperal state, as the slight degree of angina, the not infrequent complications with endometritis, and other diseases of the genital organs. Scarlet fever remains, however, always a specific disease depending on a specific though still unknown cause. An exanthem occasionally appears in sepsis. This depends mostly on embolic processes in disease of the skin, and never bears similarity to the scarlet fever exanthem. Scarlet fever remains such, in or out of the puerperal state. The same is true of diphtheria, though some observations have shown the presence of the Löffler's bacillus in puerperal cases.

The relation of gonorrhœa to the puerperal period is a still more important question on account of the greater frequency of gonorrhœa in childbed and the close resemblance of puerperal gonorrhœa to septic processes.

This is particularly noticeable in cases of acute gonorrhœal peritonitis in the puerperium. The disease begins often exactly like a septic disease, but it runs usually a more favorable course. It is generally assumed that it always runs a favorable course, as it is generally assumed that gonorrhœal peritonitis never becomes diffuse or general. I do not agree with either opinion. One sees, both in and out of the puerperium, diffuse peritonitis caused by gonorrhœa, and it appears to me probable that, exceptionally, a fatal termination results. I have seen in two instances one and the same man lose two wives in their first confinements with peritonitis.

It is evident we are not able, as a rule, to differentiate a gonorrhœal peritonitis from a septic peritonitis, nor will a bacteriological examination always enable us to decide the question. We must make a distinction, however, and not classify gonorrhœal disease in the puerperium as childbed fever.

Gonorrhœa is a specific disease which differs entirely in the manner of contagion and many other peculiarities from sepsis. The gonococci will infect an individual without a wound and forms no toxine even in a protracted habitat in the body, or at least no toxine dangerous to the organism. It does not poison the body.

Puerperal fever, in my opinion, should be a name applied only to those diseases of childbed which are caused by septic micro organisms, including anærobes, existing usually only as saprophytes in the genital canal, no matter whether the resulting disease occurs as an infection in the narrow sense of the word or only as an intoxication.—*Centralblatt für Gynäkologie*, No. 1, 1899.

MODIFICATION OF THE NEUGEBAUER-LE FORT MEDIAN OPERATION FOR PROCDENTIA UTERI (Sanger).—Several attempts have been made to devise a suitable operation for feeble elderly women, where they are unable to wear a pessary. Bellini and Freund recommended the continuous silver wire suturing of the vagina, which did not prove successful. P. Müller reports successful results from resection of the vagina, leaving the uterus *in situ* and uniting the vaginal tract, but retention tumors (hydrometra, etc.) result. Martin has employed for very large procdentia in old people resection of the vagina and extirpation of the uterus, but the operation is severe. Mere extirpation of the uterus and uniting the peritoneum and vagina may be followed later by enterocele. Sanger recommends the Neugebauer-Le Fort operation, with the following modification: The freshing is neither quadratic nor a symmetrical oval figure, but a long, transverse right angle with a slight curve or bow at the opposite side. It is extended over on one side so that

sutures completely close the vagina, with a slight opening at one side connecting the vaginal fornix with the lower portion. The freshing is at a higher level on the posterior than on the anterior wall, so that the cervix uteri is supported on an oblique septum. The corresponding margins of the freshened surface are united with continuous catgut sutures. Zweifel reports various trials of a similar method with poor success. The artificial septum gives way by gradual thinning of the cicatrix.—*Centralblatt für Gynäkologie*, No. 51, 1899.

THE TREATMENT OF INCOMPLETE ABORTION (Maygrier).—Dolérís advocates early instrumental interference. Maygrier urges the use of the finger instead of instruments, and the curette for exceptional cases only, after thorough dilatation of the cervix under chloroform. He recommends quinine in cases of delayed expulsion of the secundines.—*Ibid*.

HEART DISEASE AND PREGNANCY (Baranger).—Pregnancy has no effect as a factor in producing heart disease, and a hypertrophy of the left ventricle is, therefore, always a pathological condition. Pregnancy may develop latent cardiac disease without being the original cause. A heart-lesion may be aggravated by pregnancy, especially if the kidneys, liver or heart-muscle is diseased. This is by no means the rule, as long-standing heart diseases may be uninfluenced by pregnancy. The effect of heart disease on pregnancy is far more reaching. Hæmorrhage during and after labor, premature labor, premature separation of the placenta and diminution of the vitality of the child, are the direct consequences of heart disease. There is frequently and fortunately a certain amount of accommodation of a pregnant woman to her heart disease so that ill results are less likely to ensue. The prognosis depends on the condition of the heart-muscles, of the kidneys, liver and cardiac valves, and only becomes unfavorable when complicated with diseases of them. When interference becomes necessary Champetier's balloons deserve the preference.—*Ibid*.

AROLLIIUS EUROPÆUS AS A CAUSE OF GOITRE OR CRETINISM (S. Heller).—Besides the recognized causes depending on unfavorable hygienic conditions, Heller believes the chief causes are toxic influences, such as the continuous use of the milk of cows, in the fodder of which are crowfoot-like excrescences, and especially arolii Europæus. These poisonous plants grow luxuriantly in swampy bottoms poor in phosphates, and especially in the valleys which are the homes of cretinism.—*Prager Med. Wochenschrift*, No. 30, 1898.

THE TREATMENT OF ULCERATING INOPERABLE CARCINOMA OF THE CERVIX (Gottschalk).—The neoplasm is curetted and cauterized as thoroughly as circumstances allow. The vagina is cut around two or three centimeters below the growth, and in sound tissue, with the Paquelin knife, and the circular vaginal flap dissected up to near the infiltrated margins of the crater of the cancer. This flap is then folded in the crater so that the outer surface of the flap from the vagina lies in contact with the cauterized surface. The strips of iodoform gauze are cut large enough to pack the crater and distend the vagina below the incision. It is first removed on the seventh day. In a few days there is complete transverse closure of the vagina at the level of denudation, and the wounded surfaces unite firmly. No hæmorrhage can occur, and the neoplasm is arrested for five or six months. The excretion will recur in time,

but it never becomes offensive so long as atmospheric air has no access to the growth.—*Centralblatt für Gynäkologie*, No. 3, 1899.

GEORGE R. SOUTHWICK, M.D.

STRABISMUS IN HEREDITARY SYPHILIS.—Autonelli, Paris (*Archives d'Ophthalmologie*, October, 1898).—According to this author, many cases of strabismus are due to infections and toxins that are inherited from the parents. Of these infections syphilis is the one that is most frequently found; 50 per cent. of these patients squint in childhood.

This dyscrasia, he says, may cause strabismus through several channels. There may be trouble in the sensorial portions of the apparatus governing binocular vision, the visual acuity of each eye at the same time being up to the standard. A second cause is in the motor apparatus itself, or in the connections between this and the sensorial organs.

The intercurrent paralysis of accommodation of Javal, which interferes with the reflex of convergence, may be included in this group. The third grouping includes the manifest pathological conditions of the eye itself, such as astigmatism and rudimentary alterations of the fundus oculi.

In each eye the reflex of direction may be present, but the reflex of convergence is lacking because there is no contemporaneous excitation that is sufficiently and equally good on both sides.

TWO CASES OF DISSEMINATED EXUDATIVE CHOROIDITIS TREATED BY THIOSONAMINE.—Sueker, Toledo, Ohio, holds that the action of this drug in regard to the power to promote absorption is quite closely allied to that which is seen during the employment of iodide of potassium. It is on this ground that he uses it in the condition known as proliferative choroiditis. The improvement in vision is out of proportion to the changes that are seen in the diseased tissues. He gives the drug in ascending doses until he has reached a proportion of three grains a day, which dose, with occasional interruptions of a few days each, he continues for months at a time. In the first case reported he succeeded, in a period of about three months, in raising the vision of each eye from one-eighth of normal correction to two-thirds of normal. The glasses given at different times varied greatly. In the second case vision was raised from one-fourth to one-half. In neither instance was there any trace of specific infection.—*La Clinique Ophthalmologique*.

ON THE PROPHYLAXIS AGAINST PURULENT CONJUNCTIVITIS OF THE NEW-BORN.—Pechin prefaces his article by the statement that Europe contains at least thirty thousand blind who have lost their sight through the ravages of this disease. He disparages the Crédé method of prophylaxis on account of the danger which he considers that it possesses of clouding the cornea. In the first place he recommends a treatment of the vagina of the mother before confinement, and free washing of the eyes of the child after birth.

The first care should be offered to the eyelids while waiting to tie the cord. This attention being given, the child is to be bathed, and the eyes are to be more carefully cleansed while the eyelids are kept open. For this purpose the author uses distilled sterilized water; a little soap may be added to the water, but nothing else should be used. He considers that this simple method of prophylaxis is sufficient.—Pechin (*Recueil d'Ophthalmologie*, October, 1898).

WILLIAM SPENCER, M.D.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND
THERAPEUTICS.

CROTON TIGLIUM IN ECZEMA.—Dr. Makechnie reports the case of a woman of 30 years who had an eczematous plaque on her elbow, which was covered with pustules; this gave her a great deal of distress on account of insufferable irritation and pain. The itching particularly troubled her at night, making her restless, and also after meals. After washing it would be aggravated. Her bowels were constipated, the evacuations scanty and difficult. Otherwise she was healthy; her urine and menses were normal. During the first fourteen days she received rhus, cantharis and bryonia. These remedies ameliorated the constipation, but the eruption spread still farther and appeared on her face, it being accompanied by great itching. Then she was given croton tigl. 6x. During the first eight days the itching continued to become worse, but the eruption, particularly on her face, visibly decreased. During the succeeding week the itching diminished, her face wholly cleared up, and under the influence of the latter remedy the patient was entirely restored to health.—*Vratch Gomeopat*, No. 8, 1898.

TREATMENT OF CHOREA.—Dr. Nuños asserts that the most-frequently indicated remedies are:

Tarantula Hispanica.—Trembling and weakness of the limbs, incessant choreic movements disappearing during sleep. *Agaricus Muscarius*.

Tarantula Hispanica.—Used in both the ordinary and the severe forms, when the movements are more pronounced on the right side.

Ignatia Amara.—When the affection has followed emotions; the movements increase after eating.

Belladonna.—Where the chorea affects the flexors; the contractions of the trunk-muscles make one appear as if intoxicated.

Iodium.—Movements of the arms are so exaggerated as to hinder one from carrying the hands to one's mouth; the gait is vacillating and uncertain; convulsions of the muscles of the face and limbs.

Cuprum.—Muscular palpitations, piercing cries, contortions, with laughing gestures and melancholy; the chorea appears in paroxysms.

Mygale.—Angular choreic movements; continual winking and blinking of the eyelids; the spinal column is sensitive to the touch; itching of the eyelids and other parts of the body.

Cimicifuga.—The choreic movements are particularly left-sided, and are complicated with myalgia and rheumatism.

Zizia.—A good remedy when the movements persist during sleep.

Stramonium.—When the facial expression and aspect change unceasingly; the patient laughs one moment and cries the other; he moves his head

backwards and forwards. The contractions of the muscles of the spine and of the rest of the body are spasmodic in character.

Besides these, one may consult ambra, caulophyll., caust., conium, coccul., curare, graphites, hell., indigo, mercur., naja, natr. sulph., opium, veratr. vir., viscum alb. and sulphur.—*Revue Homœopathique Française*, tome viii., Nos. 7, 8, 9.

RANUNCULUS BULBOSUS.—This remedy acts especially on the skin, muscular tissue, the serous and mucous membranes, and, finally, antidotal to the effects of alcohol. They are aggravated by wet weather, and changes of temperature or weather.

On the skin it produces an erythema, soon followed by an eruption of vesicles, with burning, pricking and itching. They are filled with a blackish serum. These break open and become covered with thick scabs. Fever and acute pain accompany this process. The eruption usually follows the course of a nerve—the supraorbital or an intercostal nerve. If the eruption affect the forehead the eye is concomitantly affected, the ocular conjunctiva is congested, there is iritis and violent pains in the whole eye. Hence this drug is the chief remedy in ophthalmic zona as well as in intercostal neuralgia. In eczema when the skin is thickened and infiltrated, of almost horny consistence (antim. crud.).

The muscles are the seat of rheumatic pains, with a sensation as if they were bruised. They may affect all the muscles of the body, but particularly those of the trunk and chest. A pain along the whole internal border of the left scapula is characteristic; it may affect the whole chest by extension. In myalgic or neuralgic pleurodynia it is a valuable remedy; the pains are stitching, with painful points in the chest and a bruised feeling; pressure, changes of temperature and movement, even of respiration, aggravate. It may be indicated in inflammation of the diaphragm. Acute lancinating pains in the hypochondria, the epigastrium, and towards the back.

In pleurisy it often acts better than bryonia where a knife-like pain is present. If an effusion be present, it is still indicated. In pleurisy accompanying pneumonia, or in pains after it or pleurisy, this remedy is of service (adhesions).

In diseases of the mucous membranes it is employed in cystitis, irritating leucorrhœa, in dysentery with violent pains, but its place of election is that of the nose.

In hay fever it is an important remedy. There are burning and itching of the eyelids; the nose is stopped up, particularly evenings; pressure at the root of the nose; pricking, itching and burning in the nose; a sensation of something crawling into the nose posteriorly. This disagreeable sensation causes snuffling, sneezing, blowing of the nose. At the same time there is hoarseness, acute stitching pains in the chest, and general muscular pains.

Ranunculus is useful to combat the effects of alcoholic beverages, as the hiccough, the epileptiform attacks, as well as a sedative of acute alcoholic mania.—*Revue Homœopathique Française*, tome ix., No. 6.

TREATMENT OF HYPERIDROSIS.—The chief drugs are silica, thuja, nitric acid, kali carb., graphites and phosphorus.

Silica.—Cold legs and feet, with excessively fetid foot-sweat, no remedy can equal silica. Bad effects following suppression of foot-sweat. Intolerably bad, carrion-like odor of the feet.

Thuja, 3x-6x.—The patient cannot bear the least dampness, bathing, nor washing of the body. Three to four doses daily. Higher dilutions later, at rarer intervals.

Nitric Acid, 3x and higher.—Inflammatory redness of the perspiring from acidity of the perspiration. Rhagades and fissures of the skin in any part of the body. Three to four doses a day.

Kali Carbonicum, 6x and higher.—Great inclination to catch cold, and particularly to catarrhs of the nose and throat. Excessive sensitiveness to sudden sounds or noises, associated with nervous trembling or shivering, or mental indifference to surroundings. Is indicated more especially in women.

Graphites, 3x-6x.—Also particularly useful in obese women who suffer from constipation. Depression; constant occupation of one's thoughts; fear of imaginary failures in one's undertakings. After emotions, with difficulty the patient quiets down.

Phosphorus, 4x-6x.—Fatigue and heaviness of the head after the least intellectual effort; a feeling of burning along the spine and great weakness of the legs; general weakness of the body and mind.

Besides these a number of other remedies may be necessary. First of all,

Baryta Carb., 3x-6x.—Where there is a great inclination to take cold in the throat; tonsillitis; as well as in old persons suffering from asthma.

Calcarea Phosphor., 3x-6x.—Indicated by a pale and weakened skin, and a generally weak development of the body, particularly in children, and, in general, in anæmic subjects.

Petroleum, 3x.—Profuse secretion of a disgustingly offensive sweat in the axillæ and feet.

Lactic Acid, 3x.—Profuse sweating of the feet, without odor.

Bryonia, 3x.—Useful in greasy sweating of the scalp, with a sour odor; complicating catarrh of the stomach.—*Vratch Gomeopat*, No. 7, 1898.

FRANK H. PRITCHARD, M.D.

THE TREATMENT OF THE COUGH OF PULMONARY DISEASE.—For clinical purposes Macnish, of London, divides coughs into primary and secondary. The primary cough removes the secretion from the respiratory passages and stimulates its absorption. After it has completed its work, there is often left behind a cough, due to the irritation of the secretion and the primary cough. This secondary cough is not concerned with the removal or absorption of the mucus, but is often of a nature harassing, irritating and distressing both to the patient and his friends, and often producing nausea and vomiting. Obviously, this secondary cough ought to be checked as speedily as possible. Every one of us has treated numerous cases of the different kinds of pneumonia. The cough in many cases was a useful adjuvant in hastening the cure, and required no special treatment. The indications of such remedies as bryonia and phosphorus are too well known to necessitate any references. We have all proved their efficacy in pulmonary coughs. Other medicines, as antimonium tart., ipecacuanha, senega, acid. nitric., kali bichrom., etc., may be dismissed with a short reference.

Kali bichrom. 3x he has found most useful in cases of atrophic bronchitis and bronchiectasis.

Lycopodium 1x in the dyspnoea of pneumonia, especially if accompanied by distention of the stomach.

Acid. nitric. 3x in chronic lung diseases, especially where the secretions are offensive and there is a want of reaction in the patient.

Laurocerasus 3x in tuberculous disease where the cough neither gets better nor worse and an alternative is necessary.

Arsenic iodide 3x in post-pneumonic coughs, gastric coughs of anæmic girls.

Antimonium tart. 3x in the initial stages of broncho-pneumonia, especially where the smaller tubes are affected. Where the large tubes are affected and the râles very loose, he finds ipecacuanha 1x more useful.

Acalypha Indica 3x is of great value in hæmoptysis of tuberculous origin, and especially where the hæmorrhage accompanies a severe bout of coughing.

Magnesium 200 in one case relieved a cough which was ameliorated by lying down. Other drugs, as pulsatilla 3x, opium 1x, codeia 2x, iodine 3x, bromine 3x, etc., are also of service.—*Journal of the Brit. Hom. Society*, October, 1898.

THE TREATMENT OF ABSOLUTE DEAFNESS DUE TO INFLAMMATION OF THE INTERNAL EAR.—In the course of a clinical lecture, Fellows, of Chicago, says, in regard to treatment:

In the case before you I believe there is nothing now to be done, and hence I am very anxious to have you learn to diagnose the case in its incipency; for I believe that calamitous results may often be averted by timely treatment, and particularly by you as homœopathic practitioners. Houghton, of New York, reports, in his book on "Aural Therapeutics," the cure of primary involvement of the labyrinth and the acoustic nerve by scientific treatment. Knapp and some of the authorities of the regular school have reasoned by analogy that pilocarpine, because of its power of producing effusion, ought, in a physiological test, to relieve the same condition. It has been used, with more or less success, in a 2 per cent. solution, hypodermically, by many physicians. I can here gather a very important inference as to the homœopathic remedy and its power, if the case is seen in time. The sulphate of quinia, it has been proven, does produce congestion of the internal ear, with tinnitus, deafness—all authorities agree on this—which are additional indications for the use of quinine, or some of its derivatives, in diseases where the use of this drug is the starting-point.

But there is no doubt in my mind that our homœopathic remedies, such as aconite, belladonna, gelsemium, nitro-glycerin, china and pilocarpine, do exert a powerful influence toward the prevention of this disease. I believe that many cases have been cured without the knowledge of the physician, and hence it becomes important that you make a diagnosis early, and then treat the case, which in ordinary hands is well-nigh hopeless, to the best of your ability with remedies which, acting upon the nervous system, may help you to avert a disease which in its results is so terrible.—*Clinique*, November, 1898.

REMEDIES FOR THE LYING-IN PERIOD.—According to Dr. Katherine B. Clapp, arnica stands foremost among remedies to soothe the strained and aching muscles and bruised and lacerated parts.

Aconite, with its chill, rising temperature and suppression of the milk secretion.

Baptisia, with the offensive lochia, with the symptoms of infection resembling typhoid fever.

Veratrum viride, with the oscillating temperature and mania.

Secale, suppressed lochia, and always thought of where there is a black, fetid hæmorrhage.

Millefolium, resembling aconite, with its bright-red flow, without the anxiety of the aconite patient.

Caulophyllum, where there is a passive hæmorrhage, protracted lochia, with atony of the uterus.

Lilium tig., for the patient moaning from the shooting, stabbing pains in the uterus, also for the bearing-down sensation.

Belladonna and quin. sulph. are to be remembered. Strychnia and arsenic should be thought of to assist the patient in eliminating infections.—*Clinique*, November, 1898.

PHOSPHORUS AND THE TUBERCLE BACILLUS.—In discussing the cause of so-called phosphorus necrosis of the jaw in match-workers, Stockman calls attention to the fact that from existing knowledge of suppurative processes it is inconceivable that phosphorus fumes can cause a chronic purulent inflammation of bone. Instead, he believes it due to micro-organisms. With this thought, he made bacteriologic examinations of pus from six cases of phosphorus necrosis of the jaw, and in every case, in addition to the presence of staphylococcus albus, streptococci and numerous other organisms, none of which can reasonably be regarded as the cause of cario-necrosis, the tubercle bacillus was demonstrated on staining cover-glass preparations by the Ziehl-Neelson method. These were few in number and did not infect guinea-pigs, and so were regarded as being dead or having lost their virulence. The cases examined were convalescent, which might account for the condition of the tubercle bacillus.

That this organism is quite capable of setting up and maintaining the local suppuration for an indefinite time is supported by many facts. Its presence can scarcely be regarded as fortuitous, as it was found in every case. As further proof of the tuberculous nature of phosphorus necrosis are observed the facts that in most cases death occurs from tuberculosis of the lungs, the frequent existence of general tuberculosis, the almost invariable presence of tuberculosis of the abdominal glands and tuberculous ulcers of the intestines, and the occasional existence of tuberculous meningitis. The phosphorus acts by eroding the bone, weakening its resisting power, and making it, in consequence, susceptible to tuberculous infection. It is a known fact that the disease frequently develops many months after patients have given up their work in match factories. In one instance the condition occurred as late as eighteen months after—a fact that supports the tuberculous origin of the disease. Rabbits in which suppuration and cario-necrosis of the jaws had been induced, and that were afterward exposed to phosphorus fumes, have died and have been found to have tuberculosis of the lungs.—*British Medical Journal*, January 7, 1899.

[These statements will be of particular interest to homœopaths, among whom the perception of the relation between tuberculosis and phosphorus has led to the frequent employment of that drug in certain phases of pulmonary phthisis.

F. MORTIMER LAWRENCE, M.D.

THE HAHNEMANNIAN MONTHLY.

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HAHNEMANN AND ALTERNATION.

BY CONRAD WESSELHOEFT, M.D., BOSTON, MASS.

(Professor of Pathology and Therapeutics, Boston University School of Medicine.)

THE article by Dr. R. B. Leach in the April number of this journal needs some comment which will allow the position taken by the author to appear a little less one-sided than was perhaps actually intended. It is impossible to understand how anyone of thorough education in medical literature could misunderstand or misconstrue Hahnemann's directions and methods concerning what he called alternation, or what he said concerning the proper succession of remedies. No one who has ever taken the trouble to read, even cursorily, Hahnemann's works, will find there any argument in favor of the absurd routine-alternation as practiced nowadays perhaps by the majority of homœopaths, and none who has read his works with any degree of attention will fail to agree "that the logic of his whole system of medicine would confute him at every point" if Hahnemann had sanctioned, even remotely, the routine of alternation as practiced to-day. A single quotation from the *Organon* may here stand as a paradigm of all that Hahnemann has said concerning the conditions under which a succession or alternation of medicines could occur. "*As a matter of course, in*

order to undertake such a repetition of the dose, the physician must first be convinced of the entirely correct homœopathic selection of his remedy."

It has often been a matter of conjecture and of historical study with me to trace this habit of routine-alternation to its source. I can only account for it through a misconception of what Hahnemann expressed as exceptional and always as conditional, notwithstanding which, it has been made the almost universal rule. And I furthermore apprehend that this habit will last while methods of proving and the comparison of results, while certain pharmaceutical errors, and while mechanical "symptom-covering" remain as they are to-day. These things lead to uncertain knowledge of the *materia medica* which the busy practitioner endeavors to compensate for by absolutely arbitrary alternation in the most anti-homœopathic sense.

Now I regret to find that the translators of the *Organon* are made responsible for this habit of alternation. Dr. Leach takes Dr. Kraft's word for it, and where the latter got this notion I will presently endeavor to indicate. It is stated on Dr. Kraft's authority, and in an extremely intricate process of reasoning on the part of Dr. Leach, that the fault lies in a "mistranslation" of the *Organon*, and in the failure of the translators to give Hahnemann's "intent" or the "English equivalent" of his meaning. It would be useless to search out the comparatively few places where Hahnemann speaks of alternation, using the German words *abwechseln*, *abwechselung*, *wechselwirkung*. But Hahnemann did not confine himself to that German expression but occasionally used others, such as *alternirende krankheiten*, Hahnemann making use of italics himself in this. Now, it must be asked what is the English equivalent of the German *abwechseln*, and the Latin derivative *alternirend*, if alternation, alternating, from the verb to alternate, is not the equivalent?

In all such cases it is the business of the translator to give the meaning of an author literally, if possible. In not very infrequent instances a literal rendering is little better than nonsense, which can only be avoided by means of the translator's familiarity with the idiomatic use of both languages. This rule has been followed by Stratten, Dudgeon, and by me. But what

is now claimed against these translations is that they are mistranslations by not giving the English equivalent of the author's meaning. How this meaning could be given, supplied or interpreted, is furnished in the examples contained in Dr. Leach's article, where there are to be found repetitions of hypercritical remarks about the neglect of translators to furnish the "intent" or "English equivalent." As the whole question turns upon Hahnemann's sanctioning or not sanctioning alternation, one example from the article of Dr. Leach will stand for all the rest. Thus on page 216 Dr. Leach thinks that he translates Hahnemann's meaning and "intent" by using the "*equivalent*" verb "alternatively," and that, therefore, this *equivalent* and not the *literal* transcription of the verb *should* have been used.

Now, while there is no question at all concerning Hahnemann's meaning and intent, no intelligent reader will accept Dr. Leach's interpretation as to the difference between *alternation* and *alternativeness* or *alternatively*, but he will regard it as sophistical almost to the verge of quibbling. This neither has nor can have any other effect than to mystify students and young readers. For a good many years there have been attempts of this nature decrying the translations of the *Organon* as if they were unintelligible and misleading. At the same time an attitude has been assumed by some individuals as if the *Organon* were an abstruse and mystical book, the power of proper interpretation of which was vouchsafed only to certain ones endowed with a vastness of intellect unapproachable by others. The assertion of "mistranslation" justifies these words, because the phrase implies either actual ignorance or wilful wrongdoing.

Those who have the progress of homœopathy at heart will do well not to persist in this course of mystification, for that is the only word which applies to the case. The *Organon* is not a mysterious book, and its author was anything but a mystic or quibbling sophist, and if ever an intelligible book was written concerning the meaning of which there can exist not a shadow of doubt, it was Hahnemann's *Organon*. It is true that there are perhaps many physicians to whom it is little better than Sanscrit; there are undoubtedly others to whom much, or a part of it, is not clear; but to these, anatomy, physiology, chemistry, are alike unclear and unsatisfactory. For these,

perchance, the *Organon* was not written, and, like all the best books, it will ever prove to be a source of trouble to them.

But there certainly is to be found an easy way out of the difficulty. Let those who think that they can improve upon the extant translations of the *Organon*, proceed to do so at once. Homœopathy will then advance by leaps and bounds when the search-light of the super-Hahnemannian Hahnemannians is suddenly flashed upon the hitherto benighted profession groveling in the darkness of three mistranslations of the *Organon*. Nothing will be easier than to make a new translation; and when a phrase or sentence of Hahnemann is reached which the new translator thinks he can improve, let him simply add twelve or thirteen pages of commentary by way of arriving at the English "equivalent" or "intent" of what is perfectly intelligible and as plain as Hahnemann's staunch German could make it. This would only enlarge the work by several invaluable volumes; the expense and labor involved would find its reward in saving those who are now on the verge of becoming routine alternators under the blighting influence of the older translations.

But in reality things are not so bad as some evidently think. While no translation of a classical work will be equal to the original, because the forcible style and mode of expression of the author are usually untranslatable, the sense, intent and English equivalent is everywhere honestly and correctly given. The difficulty lies in this, that the qualifications on the part of the reader for its easy and complete comprehension are unfortunately too often absent. It, therefore, remains for the instructor to assist the student by demonstrating to him the simplicity and forceful logic of the book; but he would err, and it seems does err, by mystifying the student by suggestions of difficulties which are not in the book but in the mind of the student. Let him know that it is comprehensible and of clear logic, and he will take it in; while, if warned that it is a book which only certain intellects are able to master, he will fear it and let it alone, like the *materia medica*, which he fears and neglects for much the same reason. The instruction in this is not sufficiently simplified by systematic arrangement, and where this is the case the student, though informed in lectures how to proceed, has actually no time to give to such studies; he ekes out his defect by memorizing so-called keynotes, and the result is—routine-alternation.

TRAUMATIC HÆMORRHAGE OF THE MIDDLE MENINGEAL ARTERY—
A CASE UNACCOMPANIED BY FRACTURE OF THE SKULL.

BY S. M. RINEHART, M.D., ALLEGHENY, PA.

(Read before the Homœopathic Medical Society, State of Pennsylvania, Pittsburgh, Sept., 1898.)

IN presenting the following to the members of this Society I have nothing new to offer them, and no series of cases of my own from which to draw conclusions. In my surgical experience I have had only one case of the kind. Most of my knowledge of the subject comes from text-books, and in my preliminary remarks I shall have to quote a good deal without taking the time to give entire credit where it is due.

Hæmorrhage of the middle meningeal artery following accidents is not a rare occurrence. Park, in his *Systematic Surgery*, says that of all extravasations of blood that occur between dura and bone, those from this vessel constitute not only the numerical majority but the only ones of serious significance. Nor is it difficult to detect and locate if there is a corresponding fracture of the skull. But without the accompanying fracture the difficulty is much greater. The course of the middle meningeal artery is by no means constant. It is usually accompanied by two veins through the foramen spinosum, about 1 cm. above which it usually divides into two principal branches, the anterior and posterior. This point of subdivision, however, in about 8 per cent. of cases is as high as $3\frac{1}{2}$ to 5 cm. above the foramen. The anterior directs its course toward the anterior and lower angle of the temporal bone, the posterior running almost directly backward along the parietal bone. The vessel may be ruptured in either of its branches, but the anterior is the most frequently injured—why, I don't know. A rupture may occur by direct blow, or by *contre-coup*. A blow may produce the injury either by fracturing the skull—one or both tables—or, more rarely, by causing a sudden alteration in the shape of the skull, which may stretch and tear the vessel without fracturing the skull at all. In the former case, of course, the vessel is usually cut through by the sharp edges or by splinters of the fractured bone. A blow upon one temple may

injure the artery on the other side or upon the same side. Even when the fracture is upon one side, *contre-coup*, the broken artery may be upon the other side. This can only be determined by first deciding as to the probability of a hæmorrhage and then eliminating the most probable location. The amount of extravasated blood varies greatly. Two hundred and forty grains of blood-clot have been recorded, and the dura has been found separated through the entire course of the artery in both its branches down to the cerebellum. The extravasation may be rapid and quickly fatal or delayed for some time, the symptoms varying in degree and progress with the extent of the hæmorrhage.

These symptoms, upon which we have to depend for diagnosis, are not always clearly defined and conclusive, unless they are nearly all manifest in the same case, which is an unusual occurrence. As quoted by Starr from Jacobson, they consist of:

(a) Interval of lucidity or consciousness after injury.

This is perhaps the most important symptom in diagnosis. Usually, after the injury, unless the hæmorrhage is very rapid or the concussion severe and lasts for a long time, there is a period of lucidity, followed gradually by stupor or coma. Patients have gone to sleep in the former condition and passed into the latter without waking. A working man, one of Park's cases, fell upon the sidewalk while returning from work, striking upon the back of his head, was stunned for a moment, then helped himself up and walked two miles to his home. Not until next day did any untoward symptoms manifest themselves. Then he began to be restless and wandering in speech, and successively apathetic, dull, stupid and comatose.

This man upon the fourth day was trephined about 6 cm. above the left ear, and an immense extradural clot found, extending backward so far that it was necessary to make a second skull-opening in the occipital region. A teacupful of clot was removed after some effort, and the patient made an uneventful recovery in a month. This was an unusual case on account of the slowness of the symptoms, and the apparent lightness of the blow compared with the extent and amount of the hæmorrhage. The lucid interval, however, is by no means always present, even with less extensive hæmorrhages, and the surgeon has often nothing to guide him but the other symptoms, which are

more vague and inconclusive—that is, of course, providing the bone itself has not been fractured. The other symptoms are :

(b) Hemiplegia occurs on the side opposite to the injury, the face, arm and leg being usually affected, but the leg less frequently than the arm, and never alone, which is impossible from the position of the leg centres. This symptom is important if detected, but in many cases either is not recognized, owing to the unconscious condition of the patient, or is absent, owing to the position of the clot.

(c) Aphasia may or may not be present, owing to position of the clot. If present, it is strongly conclusive.

The other systems, while not so important from a diagnostic point of view, are often the only ones present to guide one in deciding whether and where to operate. These are the ordinary symptoms of brain pressure. There are some cases of brain hæmorrhage which have only the general signs of compression, but in which there are none of the local symptoms, such as those just enumerated. The general symptoms of compression are :

(d) A hard, slow pulse. Toward the end of life it becomes very rapid.

(e) Slow, embarrassed, often stertorous breathing.

(f) Hemiplegia, if present, but often absent.

(g) Condition of pupils. Dilated pupils point to cerebral pressure, and the pupil on the side of the pressure is large and frequently irresponsive to light.

The diagnosis of this condition is very difficult if only the symptoms of compression are present, and there is no scalp wound or fracture. And especially is the location hard to determine. If there are no signs localizing the lesion it is best to wait a week, if necessary, before operating, in the hope that some definite symptoms may appear.

Of the operative measures I need not speak in general terms. The principal difficulty consists in diagnosing the condition and then in locating the lesion. After that, the operation is usually simply one of trephining and removing the clot.

And now, to come from a general consideration of the subject to the specific case that brought it particularly to my attention. In September of last year a young man was brought to

the hospital by the patrol-wagon, with a history of having fallen from a buggy and struck upon his head on a fire-plug. As we learned afterwards, his horse ran away at the top of a hill and dashed down the winding road, the man trying to control him the while, until near the bottom he swerved, overturning the buggy and throwing the occupant against a fire-plug, which he struck with his head. The patient's condition was as follows: External marks, none, except a contused area in region of right temple, at or very slightly above the level of the upper margin of the ear; pupils slightly contracted; patient unconscious, but able to be roused enough to resist efforts of attendants; very restless; vomited shortly after admission; no impairment of movements of limbs; breathing heavy, but not stertorous. The symptoms at this time were those only of shock and concussion. During the night he was very restless, but seemed to sleep naturally at intervals for half an hour at a time. The nurse's record says that he complained of his head hurting him in frontal region, and that "he asked for a pillow to put under his head." At this time he was evidently coming out of the condition of shock and the effects of concussion. In the morning, when I saw him, he had lapsed into an unconscious state again. The pupils were now dilated, and there was evidence of cerebral compression, the location of which was in doubt. But the gradual lapse into unconsciousness after a period of partial mental activity, and the location of the external mark of contusion, gave reason to believe that there might be either a fracture of the skull, causing compression upon the surface of the brain at that point, or more likely a hæmorrhage of the middle meningeal artery at that place, either with or without a fracture. It was decided to trephine. I made a large U-shaped flap in the usual manner, beginning below and forward quite beyond the margin of the hair, and taking in the whole temporal region. There was no evidence of fracture throughout the whole exposed area. At the site of the contusion the periosteum was lifted and a button of bone about one inch in diameter removed by the trephine. Upon its removal there welled up from the opening a great quantity of bright red blood, which came from between the dura and the skull. The button of bone removed was smooth, and gave no evidence of fracture of the inner table. As quickly as possible

the opening was enlarged in the direction from which the blood came, but so profuse was the hæmorrhage that efforts had to be made at once to check it. The dura was carefully incised. Beneath it was a large clot, pressing upon the surface of the brain, which, upon removal, left quite a good-sized cavity, from which bright red blood gushed in such quantity that the patient was in immediate danger of becoming exsanguinated, so that further efforts to enlarge the bony opening to discover the rupture in the artery were stopped and the cavity beneath the dura was packed with gauze. This compressed the vessel between the packing and the bone, and gradually brought the bleeding under control. The scalp-flap was then replaced and dressings applied, leaving necessary drainage. Following the operation, the patient's symptoms were of about the same character as before; that is, symptoms of cerebral compression, probably slightly aggravated by the pressure of the gauze packing. Once during the night he roused enough to get out of bed to urinate during the absence of his attendant. Upon the following day he was removed to the operating-room, and an attempt begun to remove the gauze which filled the wound; but this was desisted, because of a fear of renewing the hæmorrhage, and he was returned to his room. During this second night his symptoms were more marked. The stupor was greater, the muscles of the face twitched spasmodically, swallowing became difficult, and the pupils were widely dilated, especially the right. Upon the third day the flap was again lifted and the gauze carefully removed. This did not renew the bleeding. The bone was quickly cut away anteriorly, and the broken anterior middle meningeal ligated. Then all clots were washed away with salt solution, and the wound stitched and dressed in the usual manner.

The subsequent history of the wound was one of almost complete union by first intention, in spite of its having been opened thrice on succeeding days. The patient's mental symptoms, however, were more important, as they did not clear up rapidly. For two days he hovered between life and death. There were the same restless tossing, the intervals of complete stupor, the irregularly dilated pupils, though this symptom was not so marked, that characterized his previous condition. Upon the third day after the final operation there was marked improve-

ment. The temperature, which before this operation had been as high as 101° , was at no time on this day above 99.2° , and thereafter became and remained normal. He took his nourishment well, slept quietly at intervals, and his intelligence seemed to awaken into activity. But speech, which from the night of his admission had been dormant, was still slumbering. From this time improvement in all mental faculties was steady and progressive, and need not be particularized. On the fourth day after the final operation, or the seventh after admission, he distinctly uttered speech twice. Once, and I believe first, he said: "Ah, mamma!" and again, after finishing a cup of milk: "All gone!" After this the aphasic symptoms gradually cleared up, and upon the ninth day he discovered himself, began to learn the names of objects, and to take up the activities of an intelligent consciousness.

The principal points to be emphasized in this paper are:

1. The comparative rarity of a hæmorrhage from this artery without a corresponding fracture of the skull, and the principal diagnostic symptoms enumerated above, especially the interval of consciousness, the irregular pupils, the hemiplegia and the aphasia.

2. The difficulty of localizing the hæmorrhage, which may be anywhere in the whole course of either branch of the artery. Dr. Roswell Park claims to have been the first to operate on this condition, according to the principles of cerebral localization, in 1886.

3. And this concerns my particular case: The aphasia was one of the most marked symptoms. Not a sound did our man utter, after the symptoms of compression became manifest, until the seventh day after admission. I did not mention it above, but I want to call your attention here to this fact—he was and is a right-handed man. We are told and believe that in such the aphasic area is on the left side. This hæmorrhage that we have been describing, with its clot formation and consequent brain compression, were on the right side, and were, as far as can be judged, entirely cleared away by operation. The aphasia did not begin to disappear until the fourth day thereafter. Now, was there also a left-sided hæmorrhage by *contre-coup*?

A CASE OF EXANTHEMATIC PURPURA; ITS SUCCESSFUL TREATMENT
WITH KALI IODATUM; PURPURA FROM THIS DRUG.

BY FRANK H. PRITCHARD, M.D., MONROEVILLE, OHIO.

ABOUT two weeks ago I was called to a little girl of nine years who had been suffering from impetigo contagiosa of both legs below the knees. The right leg was nearly wholly covered with pustules in active suppuration, while the other presented a number of these lesions in the stage of desiccation. She had about a degree of temperature, her pulse was a little accelerated, her color paler than usual, her appetite slightly below normal; otherwise, her condition was satisfactory. I sent her a salve of vaseline and white precipitate, the ammonia-chloride of mercury, twenty grains to the ounce, to be applied locally twice a day, and gave internally cicuta. I have to thank Dr. Graham, of Philadelphia, for this therapeutic hint, which I have found very serviceable in the treatment of this disease. I had at one time a veritable epidemic of this distressing skin disease in the little community where I formerly practiced, and I must confess that my results with iodoform in salve form, carbolic acid in salve and solution, as well as other drugs, were decidedly discouraging. These cases would run on for weeks where, with the white precipitate ointment, they would be cured in one to two weeks.

That day, when first called, the mother had been alarmed by the child's hands suddenly swelling up as if stung and becoming bluish-red.

Two days after my first visit I was sent for again, as her hands, immediately after rubbing on the salve, had suddenly commenced to swell, and she had broken out all over her body with dark-reddish and irregular blotches. Her eyes were also puffed. The eruption was symmetrically spread on both sides of her body, with angry red wheals like urticaria on her arms, hands and feet. These itched uncomfortably. I diagnosed purpura exanthematica, due to a dissemination of the toxins of the impetigo, through the rubbing in of the salve. It was later noticed that any emotion, walking about, or a cold draft would also bring out fresh crops. I gave apis 2x and continued

the treatment with the white precipitate. The following three days were passed in the same condition, with some aggravation from appearance of successive crops of purpura, until the child was quite full of the blotches. Her general condition was only fair, though there was hardly a degree of temperature.

On seeing her then in my office, I remarked a close resemblance of the eruption with that produced by an overdose of the iodide of potash. The absence of visceral hæmorrhages and fever excluded a hæmorrhagic purpura, yet two other children breaking out with the same eruption made me suspect its infectiousness. Some of the pus examined under a microscope revealed a streptococcus which easily stained with Loeffler's solution of methyl-blue.

Accordingly I gave kali iodatum, ten grains in four ounces of syrup, one-half a teaspoonful every two hours. In one and a half days the whole eruption had disappeared, and her skin was as fair and clean as before. The little fever had dropped, her appetite returned and she felt well. The impetigo healed within a few days after that under the same salve.

Of the other children, one had had a similar eruption, but far less numerous, the other a slight tonsillitis.

In a recent article in *La Semaine Médicale*, No. 29, 1898, Prof. Rendu, of Paris, reported a similar case. He directs attention to tonsillitis, pleurisy, furuncle, erysipelas, tuberculosis or the grippe as the ways of entrance of infection. No specific microbe has been isolated through which the infection gains entrance. He explains the purpura as due to the toxins of the germs.

The polymorphism of the eruption was one feature which directed my attention to kali iodatum. The urticarial wheals are decidedly characteristic; the purpuric spots are also so, but by far less frequent, for some great syphiligraphers have said that they have never noted them from overdoses of the drug. Fournier mentions it incidentally as *iodisme pétéchiâle*, and thinks it very rare. Fischer, *Wiener Medizinische Wochenschrift*, 1859, divides the skin manifestations of kali iodide into four forms: the erythematous, the urticaria-like, the nodulopustular and the petechial forms. The urticarial wheals are described by him as *intensely red*, without fever and appearing on the abdomen and extremities usually, but also on other parts

of the body. These are but slightly raised, collected into groups, only distinguishable from a genuine urticaria by their intensely red color, which is usually described as rose-red and disappearing on pressure. This description would cover the urticarial lesions of my case. As to the purpuric manifestations, Dr. Mackenzie reports the case of a syphilitic child of five months, who, after taking a dose of grs. ijss. of the iodide of potash, in about three-quarters of an hour noticed it turn black about the mouth and chin, with a similar appearance on the other parts of the face. On being brought to the hospital, there was observed a large, dark, hard discoloration of the lower lip, with separate dark spots of purpura around it. There were a few hæmorrhagic spots on the left arm above the elbow; no others elsewhere. While it was watched, the patches perceptibly increased in size until, in an hour or so, the scalp and face were well covered. The next day the purpura had become more general, and on the fourth day the child died.—*Medical Times and Gazette*, 1, 173, 1879.

The swelling of the hands and wrists is found also under iodine; for Burt, *Physiological Materia Medica*, p. 489, cites Kuess, of Strasburg, who has not infrequently met with œdema of the eyelids, the skin of the abdomen and forearm, in connection with iodism. He further quotes Bazin to the effect that the iodine exanthemata assume three different forms. The mildest is the erythematous, which appears in the shape of more or less universal urticaria-like knobs.

Stillé, cited by Burt, says: "In some cases ecchymosis or purpura of the inferior extremities has been observed."

Dr. T. M. Anderson, *A Treatise on Diseases of the Skin*, 1887, cites Dr. Stephen Mackenzie's address before the meeting of the British Medical Association on the classification of purpuric condition, who states that among other drugs the iodides will produce it.

Prof. Kobert, *Lehrbuch der Intoxikationen*, 1893, p. 374, states that urticaria-like eruptions, erysipelatous and œdematous swellings have been observed after acute poisoning by the drug or its compounds. Not only this, but epistaxis, hæmorrhages from the lungs and kidneys have also been noted, so that in a given case, if hæmorrhage set in with purpura, the drug would still be indicated.

Anderson states that the difference between exanthematic and hæmorrhagic purpura is merely one of degree. Both may be due to the toxines of infectious agencies.

Dr. H. Lilienthal, *Homœopathic Therapeutics*, Philadelphia, 1879, p. 625, gives both iodine and kali iodatum as drugs indicated in purpura, though he prefers, apparently, bryonia, cro-talus, hamamelis, phos. and acid. sulphur. in both the simple and hæmorrhagic varieties.

Dr. Arthur Van Harlingen, *Wood's Reference Handbook of the Medical Sciences*, Vol. II., p. 412, in discussing medicamentous dermatitis, among other drugs finds "a purpuric eruption due to the ingestion of iodine or its compounds to be now and then met with. It may be brought on even by minute doses of the drug, the case of an infant having been reported where a fatal result was caused by a single dose of two and a half grains. Usually, however, the eruption is not severe and is found upon the legs. Now and then other hæmorrhages may be caused simultaneously. It is generally produced at an early date from the first exhibition of the drug, but its appearance is occasionally delayed until the drug has been administered for some time. The purpuric eruptions cease as soon as the drug is discontinued, but may be reproduced by even minute doses.

I have seen the iodide of potash cause an urticaria-like eruption after it had been given in two-grain doses for a month or so three times a day. The eruption was very distressing, persistent, appearing in successive crops *for over a year after stopping the drug*. It would reappear again with disagreeable tenacity from even a minute dose of the iodide, or even from merely touching the tincture of iodine to the skin. The patient became discouraged, and despaired of ever being free from her eruption. Nothing appeared to affect its course.

Certainly the therapeutic effect of the iodide was striking, and that after the failure of apis 2x I might have given this latter drug too strong, yet I have seen best results from apis in cutaneous diseases when administered thus. It might also be objected that I also gave the iodide too low—ten grains in four ounces of syrup. Possibly I did. At all events, no untoward results followed.

In a curious old Latin work that I possess, by Franciscus Boissier de Sauvages, Professor Regius of the University of

Montpellier, France, in an attempt to class diseases according to the botanical arrangement of Linnæus, under Classis III., Phlegmasiæ, he wisely arranges under the third division of Purpura, purpura symptomatica, *Nosologia Methodica Sistens Morborum Classes*, tomus primus, p. 448. He goes on to state that: "Ea est quæ aliis morborum generibus supervenit, nec eos judicat, nec in illis constans est, nec in morbo incremento observatur; morbiquibus illa jungitur, non petechiales, sed *petechizantes* a Junkero & Nentero cognominantur, et tales sunt omnes febres remittentes, potissimum typhi, . . . omnes phlegmasiæ exanthematicæ." Ludwigius contended that purpura maligna was contagious in that early day.

ALCOHOL AS A MEDICINE.

BY E. L. HINMAN, M.D., OSWEGO, N. Y.

(Read before Central New York Medico-Chirurgical Society, Syracuse, N. Y. June 2, 1898.)

THE medical profession is largely responsible for the delusion so persistently held to by millions that alcohol is good for man, and that its abuse only is to be condemned. In days long gone by the alchemists were endeavoring to find a panacea for all the ills to which flesh is heir. When, by the process of distillation, spirits of wine, or alcohol, was produced, it was proclaimed to the world with joy that the long-looked-for cure-all had been discovered. The medical men of the age prescribed and introduced it to their patients, and were lavish in their praises of its curative powers. Being a drug which very rapidly creates a liking for itself the demand became very great, and as time advanced people began prescribing it for themselves, until its use in various forms became almost general.

If the medical profession is responsible for the widespread belief that alcoholics are of service to mankind, it should not be forgotten that it is to members of the same profession the world is indebted for the correction of these errors. All down through the centuries since alcohol was discovered there have been physicians who doubted and opposed its claims to merit. It remained for the medical science of the latter half of the

nineteenth century to clearly demonstrate, with nicely-adjusted chemical apparatus and appliances, the wisdom of these doubts.

Leading medical scientists of America, England and Continental Europe have for the last twenty or thirty years been making the drug alcohol a special study. The most careful and elaborate experiments have been made as to its heat-producing properties, its strength-giving qualities, and its effects upon the different organs of the body. Dogs were exposed to a frosty atmosphere, one with alcohol in his body the other without. The one with alcohol would die from the cold, the other would be as well as usual. With men, the tiny thermometer under the tongue revealed a normal temperature of $98\frac{1}{2}^{\circ}$ F. Shortly after alcohol was swallowed the temperature would increase a degree or more; but soon it would fall again, and keep falling until it would go a degree or more below normal, showing that after the flush of a drink is over a man is colder than before he took it. In the arctic explorations of Captains Ross and Parry and Dr. Kane, they discovered by actual test that alcohol did not keep out the cold, and that men were injured or killed by the cold far quicker if alcohol had been taken.

Thus it was proven that the old idea that alcohol warms the body is a delusion, and exactly the reverse of the *facts* in the case. This revelation of science is now accepted by all of the medical fraternity who keep up with the age. In proof of this, remember that where brandy is now used in fever it is to *reduce* temperature; and when a man is found in summer upon the street, and it is doubtful whether the case is apoplexy or solar alcoholism, it is settled by the little thermometer being placed under the tongue. The strength-giving properties so popularly credited to alcohol were found to be as much of a delusion as the heat-giving. It was shown that muscle becomes flabby, and with some kinds of drinks fat, where it should be strong and tense, the heart is deranged, and every organ of the body suffers in proportion to the amount of alcohol taken into the blood. The power to deaden the nerves of sensation accounts for the hold this drug has on the people. It is simply a narcotic. The laity will not believe, or have not been told, that their feeling of strength comes from the deadening of the nerves which gave the warning signal of fatigue; that the sensation of hunger passes away for a time because the nerve of hunger, the

pneumogastric, is benumbed; and so of other sensations allayed temporarily by this deceitful drug. As you all know, it is disastrous to mask symptoms. The Creator designed that when our nerves cry out, "Fatigue," we should rest. When they say, "Hungry," we should eat. By pouring into the stomach a drug which causes a person to go on working when worn out, or to neglect food when the engine runs low for fuel, life is shortened. Says Dr. N. S. Davis, Sr., of Chicago, one of the foremost men in America in medical ethics: "After years of prescribing alcohol as a tonic, I found by close study it was of no real value. The anæsthetic effect diminished their feeling of weakness, but it gave them no strength; here was the delusion. Just like ether, chloroform, or any other anæsthetic, it removes for the time being the consciousness of aches and pains; a little further and the patient becomes hilarious. The world calls that excitement evidence of stimulus; but instead of accepting that verdict analyze it, and it is exactly parallel with any other anæsthetic. The patient goes through exactly the same stages as chloroform."

A number of observers have been making thorough investigation by measuring the exact effect of small doses upon the special senses, and they have all come to the conclusion that from the very first alcohol acts upon the body as a narcotic, and not as a stimulant.

It has the same effect upon the mind as opium or chloral; it causes mental processes to be slower, but gives the impression that they are faster. This explains how people sometimes continue its use when others readily see that it is harmful to them.

A true *stimulant* produces not only an excited action, as in the case of the heart, but causes the entire body to do better work. Distinguished scientists in all countries now agree that alcohol, opium, chloral and tobacco are cerebral poisons. Alcohol is an inveterate water-drinker. This is the key to most of its action upon the human body. It will draw water out of all substances it comes in contact with, and will extract it from air, if left uncorked. Alcohol is thus used to preserve many substances, as all decay is stopped when the moisture is extracted. It has been lately found, however, that glycerin will preserve them equally well.

But if alcohol preserves dead tissue, it cannot preserve living tissue. It first kills, then prevents decay. All the parts of the body are moist, and are kept so by water. The blood has almost four times as much water as solid matter. It is necessary that the blood be very fluid in order that it may flow freely through the vessels. The process of oxidation of the blood is impeded to an extreme degree by the presence of alcohol. It renders the blood-vessels deficient in power, and the course of the blood through the vessels is readily checked. The red corpuscles lose their water, and thus shrink, and masses of them form, obstructing the flow; then the fibrinous part of the blood becomes thickened and stops the circulation, and death is rendered inevitable.

In the stomach it impedes digestion and produces ulceration. The liver suffers second only to the brain; for here it produces congestion, enlargement, hardening and cirrhosis. The substance of the kidneys is so changed that they cannot perform their function, and thus the poison they should excrete remains as a disturbing element in the system. This poison in the blood destroys the epithelium of the glomerulus and the uriniferous tubules, and thereby allows the rich albumin of the body to escape in the urine. In the bowels it produces relaxation and irritation; in pulmonary organs, congestion and bronchitis.

The effect of alcohol upon the heart, exerted through the nerves that control its action, is no less serious. As you know, it has three distinct sets of nerves—one coming from the brain, the second from the second ganglion of the sympathetic system, and the third from the ganglion imbedded in its own substance. This careful guarding shows how important is its action; it also renders it more vulnerable to attacks of alcohol on the nerve tissue.

Alcohol increases the work of the heart by causing it to beat faster. This is due to relaxation of nerve control over the minute muscular bands of capillaries and arteries. As we have seen, in their natural state these have exactly the right tension to regulate the flow of blood, and consequently the amount of resistance offered to the heart-beat, and this of course determines the frequency of its pulsation. Relieve this tension by stupefying the nerves so that they relax their control over the muscular coats of the arteries, resistance is lessened, and the

heart beats faster. When the spur of alcohol is removed, the heart fags from exhaustion, beating slower than natural, thus showing its inability to perform its ordinary work.

Let us look a little more closely to the work of alcohol in the realm of involuntary action, for here its most deadly work is done. Take, for example, the capillary system, through which the blood is carried to nourish every part of the body. The will has no control over this action; it is controlled by nerve-fibres of the sympathetic system dipping into every cell of the muscular coating of the blood-vessels. In their natural state these contract and expand in exact measure to give each fibre of the living organism its meat in due season. Alcohol deadens these little nerves, causing them to relax their hold, the capillaries become dilated, and more blood than is needed flows to the part, causing the flushed face of drinkers.

Passing now to the moral effect of alcoholics, we find them epitomized in a weakening of the will power and a tendency to untruthfulness. These are the natural results of alcoholic action on *nerve* tissue. The will acts through the brain; paralyze that, and a weakened will, or, what amounts to the same thing, weakened manifestations of it, inevitably follows. This deprives a man of power to resist temptation. It is not necessary to become a hard drinker to realize this loss of will power. The moderate drinker is continually destroying his will power.

We have not time here to take up the subject of heredity, but the awful thought confronts us that not only the appetite but the weakened will can be transmitted to children. What richer inheritance can be bequeathed to a child than a strong will power. But when we see insatiable appetite pulling against a weakened will we need not wonder at the results. The weakened will leads not only to laziness but to general shiftlessness, thus impairing a man's value as a citizen.

Untruthfulness can be traced back to alcoholic action upon the nerves of special sensation. These, *disordered*, do not convey truthful impressions to the brain, and thus the *muddled* brain cannot convey accurate reports to the mind. While this is undoubtedly the root of the evil, many other elements unite to produce the most melancholy effects of drunkenness—tendency to falsehood, which affects not only the drinker himself, but his posterity.

Having looked at alcohol in its effects upon the human system—effects which are all negative in their character—where is it necessary as a medicine? In fact, can it be called a medicine? The word medicine, coming as it does from the Latin word “medeor,” signifies “to cure.” Where does alcohol perfect any *cure* of disease?

It is true that a physician can make the anæsthetic properties of alcohol available for the temporary relief of pain and the induction of sleep; but it is equally true that he has many other remedies more efficient for these purposes, and less objectionable, than alcohol. Consequently, I say the use of alcohol is not necessary. Rather the disuse entirely than the indiscriminate use so alarmingly common in the medical profession of to-day.

Since the active alkaloidal and resinoidal principles of roots and gums have been isolated and put into better and more convenient forms, there is no longer need of alcoholic tinctures, elixirs, etc.

In the place of laudanum we have the valuable narcotic and hypnotic principles of opium contained in certain crystalline bodies which can be isolated and used in minute and more convenient forms, and they can be held in aqueous solution. Dr. Paine, of Philadelphia, says: “Alcohol is never useful as a medicine, as there are no circumstances or conditions where other agencies are not more useful and free from poisonous influences of alcohol. Even for the preparation of tinctures and to prevent fermentation, glycerin, salicylic acid, bisulphite of soda, lime, potassium, and many other antiseptics and solvents, are preferable.”

Whatever excuse there may have been for its use as a medicine when knowledge was more limited, there certainly can be none at the present time.

Dr. B. W. Richardson, an eminent London physician, maintains that alcohol has a certain use as a medicinal agent and that physicians have a right to prescribe it; but, says he, “In common fairness to scientific progress, the professors of healing ought so to prescribe alcohol that nothing shall be wanting in accuracy of the prescription. The exact amount, quantity, quality or purity of the alcohol ought to be known, if prescribed at all.”

It is the duty of the physician so using alcohol to define the dose and to direct the time of administration with the same care as if he were prescribing opium, chloral, or other narcotics.

Let us look at some of the changes that have taken place in the uses of alcoholics in disease during the last few years.

Dr. Higginbottom says: "I was educated to think that port wine was absolutely necessary in the low and sinking state of typhus and typhoid fever, but I found a much better remedy in ipecacuanha."

Another complaint which he thought required port wine or brandy was post-partum hæmorrhage. Several severe cases he relieved by producing vomiting, thus emptying the stomach.

He quoted a leading physician, who had an extensive obstetrical practice for years, in which he says: "Having commenced the emetic plan, he never knew it to fail in checking the hæmorrhage, although he does not resort to it until ordinary means have failed."

In my own practice I produce vomiting either with an emetic or by irritation of the fauces. Having once completely emptied the stomach, I give drop-doses of the ϕ of ipecacuanha, always with good results. In delirium tremens the emetic treatment is invaluable, ipecac being preferred to any other emetic.

Periodical drunkenness, which may be considered a disorder, is successfully treated in the same way. When a person is in that state it will be found that his stomach is in fault, and that the unnatural appetite arises from a vitiated secretion. Let half a drachm of ipecac be taken, so as to produce full and free vomiting, and the desire for stimulants will be taken away, and the circulation, which was impeded will be restored. Ipecacuanha is an invaluable remedy in disorders and diseases in which alcoholic stimulants have been thought necessary. I do not know another medicine equal to it in the whole of our materia medica, both in the commencement of the disease and also in the sinking state.

In my own practice I have found the use of glonoine, strychnine, digitalis, caffeine and convalaria, as heart tonics, far superior to alcohol for restoring permanent steadiness and force to the circulation. In cases of shock, and other forms of sudden and severe depression and exhaustion, we have in the ammo-

nias and camphors, together with glonoine and digitalis, far more speedy and efficient remedies for arousing the sensibilities, especially when aided by a dash of cold water, followed by any of the heart tonics.

In case of anæmia, port wine and other alcoholics are certainly useless. Iron is the best remedy, in conjunction with pulsatilla and sepia, the best form of iron being found in our mineral waters. Change of air is very beneficial, oftentimes. One word more in reference to the action of alcohol on the living organism. In 1883 it was found, by direct experimenting upon animals, that the presence of alcohol in the blood much intensifies the action of chloroform, and thereby renders a smaller dose fatal. The celebrated experimenters, Ringer and Sainsbury, in closing their report on the "Action of Alcohol," say: "By its direct action on the cardiac tissue this drug is clearly a paralyant, and this appears to be the case from the outset."

The use of alcoholics, so common in the practice of some members of our profession, is largely the result of routine practice, a matter of convenience, or perhaps a yielding to the tastes and wishes of patients and friends. It is so easy to fall into ruts that many do so, and continue therein without ever discovering the fact. If the imperfections of human nature are such that some degree of routine practice must be expected, the physician should at least use enough care to fall into that routine which is harmless. There is no class of remedies where adulterations are so common, and more to which the patient is so apt to cling after the necessity for medication has passed, and surely none that leaves in its train such a fearful catalogue of results. Alcoholics are far more agreeable to most men than other remedies. The physician, of course, likes to please his patient. The latter comes with the inquiry whether a little wine, gin, brandy or whiskey would not be advisable.

The doctor yields oftentimes when he doubts not but that some other remedy would be preferable. He is not besieged in this way about belladonna or strychnia, but this fishing for an alcoholic prescription is quite common and far too successful.

In addition to the established theories and settled convictions of eminent medical men who have given this subject their careful thought, look for a moment to the actual experience of men in all ages of the world's history.

From the day that Daniel stood before King Nebuchadnezzar, and demonstrated in himself and his associates the superiority of cold water and pulse over wine and the king's meat, down to the latest encounters of modern times, where muscle or brain, physical or mental superiority, has been demonstrated, the entire written and unwritten testimony of human experience is that alcohol is not only not required but is decidedly pernicious, if the object be to strengthen or build up the human system.

ONANISM* AND ITS RELATION TO INSANITY IN THE MALE SEX.

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THE existing and pernicious habit of masturbation pervades all classes of the human family. It is practiced in all countries, at all times and in all grades of society, regardless of servitude or luxurious ease. One has but to notice the offspring of people addicted to this habit to behold the living mortuaries of a civilized race.

Notwithstanding all that has been said and written against the secret vice, it still exists; the depraved teachings of evil associates, the reading of licentious literature and the neurotic legacies of parents to their sons are the reasons responsible for its unwelcome appearance in each succeeding generation. Onanism is not solely a habit of education. It occurs among the educated as well as among the uneducated, among the civilized as well as the uncivilized, and in the lower forms of the animal kingdom as well as in the human race. It has been observed in cannibals and in different barbaric tribes; dumb animals, especially monkeys, may be seen almost daily to practice it in our menageries. It occurs in children who are too young to understand the cause which incites them. Savage reports the case of a precocious child whose sexual instincts were so aroused that he began to masturbate at the age of five.

* The word onanism, in its general application, is held to mean any perverted method of producing an orgasm. In this article the terms onanism, masturbation and self-abuse are used as synonymous words descriptive of the same vice.

Some of the causes given are nervous heredity, faulty education, solitary confinement, political, religious or social commotions and consanguineous marriages. One cause which is often overlooked is a tight and elongated foreskin. The secreted smegma, having no means of outlet, collects in cheesy masses and forms layers around the corona; this irritates the sensitive nerve-terminals, thereby calling the individual's attention to that organ, with the subsequent formation of the habit. Then, too, some nurses should shoulder the blame of children who stumble into the pitfall of their own destruction. A great many times, when infants have been cross, fretful, restless, irritable and crying, the nurse has titillated the glans penis to quiet them, thus ushering into the lives of these innocent babes the advent of a most disgusting and destroying vice. The extent to which masturbation is carried on differs in different localities; the city lad is more addicted to it on account of the environment in which he lives than he who is reared in the country. Some boys, with good strong constitutions, indulge in it for a while, then suddenly, becoming alarmed as to the probable result of such acts, cease entirely; while others, undermined by a weak and neurotic heredity, need but the slightest acquaintance to become slaves to this evil, and slowly but surely sink into the inextricable quicksands of terminal dementia. Among the first symptoms noticed in children who are becoming addicted to this habit are slyness and indolence; later, they become suspicious, mean and cowardly; they will strike their playmates and relatives on the slightest provocation, and are cross, irritable and snappish when their whims and fancies are not immediately gratified. If their condition is not recognized in time and put under proper treatment, their symptoms increase, they become stupid and apathetic, their minds impaired and their memory weak; but, nevertheless, they masturbate with unfailing regularity, and are sly enough to hide their loathsome practices from the keenest observer in the family. At last their memory becomes so poor, their actions so foolish and their conduct so unbearable that they are sent, in a state of dementia, to some institution for care and treatment. There is an erroneous idea prevailing amongst the laity, and some in the profession, that from 80 to 90 per cent. of the poor unfortunates who pass through the portals of an insane asylum are

confirmed victims of onanism. Such an impression is surely unfounded. After carefully searching the records of the last 2000 cases admitted to the Middletown State Homœopathic Hospital, I find that in only 6 per cent. was onanism given as the direct and exciting cause.*

I do not, however, mean to convey the idea that only a small percentage masturbate—much to the contrary; for I believe that some time during the course of nearly every form of mental disease there is a period when onanism is practiced to a considerable extent, but it cannot be attributed as a cause, but rather as a symptom of the already existing cerebral disease. There are patients who enter asylums who have never masturbated to any great extent, but who have been very intemperate in venery.† This class, on finding themselves cut off from the usual means of satisfying their morbid desires, readily take up with onanism as the only available substitute. Dr. Kellogg, in speaking of onanists, says: “Masturbation appears in single adults of both sexes, and even in married persons as a matter of choice in the mode of indulgence, and if it caused insanity as often as some claim, the whole race would long since have passed into masturbatic degeneracy of mind.”

The symptoms exhibited by the confirmed onanist differ materially from those noticed in the young. The slyness, cunning and intolerant conduct of the latter disappear, and in their place we find ungrounded suspicions, uncontrollable fears, apprehensions, and destructive and suicidal impulses in he who has become insane. Melancholia, stuporous insanity and the insanity of pubescence are given by Spitzka as the forms more usually found in masturbators. He says that the prognosis of the psychosis associated with onanism is bad. Clouston, on the other hand, claims as high as 34.78 per cent. of recoveries, besides improvement in many. That form of insanity caused di-

* It is most difficult to obtain authentic information concerning this class of patients. The friends and relatives are not always correctly informed, and, where so, reluctantly part with their knowledge. To rely upon the person afflicted is absolutely absurd, as all masturbators are “Falstaffian liars.”

† It is believed by a number of alienists that excessive onanism, in the majority of instances, primarily affects the spinal cord, thus favoring the development of spinal disease, and, later, that of the brain; while excessive venery acts directly upon the cortical centres, producing degeneration of the brain.

rectly by masturbation is very insidious in its onset. It may make its appearance by feelings of a morbid nature or by a religious condition which is very shallow and emotional in its character (Shaw). There is no connection between the thoughts of a patient and his following actions. He is painfully egotistical, foolish and important. Hallucinations of the special senses,* taste, smell, and hearing, are quite frequent, and are of grave import as a prognostic sign. As the disease progresses, there appears a stage of depression. Here the patient is exceedingly hypochondriacal; he complains of aches and pains in almost every part of his entire anatomy; he will sit and brood over imaginary wrongs for hours at a time; his affection and love for relatives become estranged, and he seeks seclusion, especially from those of the other sex. Suicide is often thought of but rarely accomplished, on account of the poltroonish tendencies exhibited by these patients. During the course of the disease outbursts of maniacal excitement are common, masturbation is practiced openly and shamelessly, and obscenity and profanity are evidenced to a marked degree. At any time recovery may ensue, but its occurrence is rare, the majority of cases terminating in mental enfeeblement. In this state periods of excitement occur, the individual being unfriendly and belligerent, and prone to acts of violence.

Physically, the masturbatic dement presents a scrawny appearance; is thin, pale and haggard; appears to be suffering from incipient phthisis, and, although he may eat enormous quantities of food, he does not increase in weight; his hands are cold and clammy, and his eyes are cast down as if either ashamed or afraid to look one in the face; with all this there is palpitation of the heart, flashes of heat to the head and face, pain in the loins, head and back, and weakness of the eyes. The prognosis in this form of insanity is unfavorable, as few ever recover sufficiently to take care of themselves or others.

The following is a case of masturbatic insanity (dementia):

CASE No. 4450.—Age, 22; male; white; clerk. Admitted July 23, 1893, having been transferred from a private sanita-

* "Impressions from the sensitive nerve-terminals of the sexual organs are received in the cortical cells at the posterior part of the tactile area, a region contiguous to the visual and auditory areas, and possibly overlapped by them; hence the olfactory and gustatory hallucinations in masturbatic insanity."

rium. No heredity. Has masturbated from infancy. Imagines his people have maliciously treated him, and says if he is insane onanism is the only cause. Has delusions of a religious character; imagines he is the Christ, and is arrogant, conceited, and proud of his position among men. He jumps from one subject to another in an incoherent manner, and is continually complaining of a headache, as if a weight were placed upon his head. For six weeks he improved, and worked around the ward. Physically he gained, having added a number of pounds in weight. On November 3, 1893, he was discharged as improved. He was readmitted July 3, 1895. His hands were cold, blue and clammy; he talked in a rapid, rambling way, and there was a "hang-dog" expression to his countenance. He was extremely nervous, dull and stupid, constantly biting his finger-nails, and walking up and down the ward in an aimless manner, with his hands in his pockets and his eyes cast down. All this time he masturbated shamelessly, and did not seem to appreciate the fact that others were observing him. At the present time he is still in this hospital, noisy, restless and quarrelsome by spells; he still masturbates and jabbars incessantly to himself; is growing more and more demented. This dementia will end in complete vacuity unless some inter-current disease takes him off, death finally closing the scene.

CASE No. 3939.—An erotic imbecile; age, 21; white; occupation, none; admitted August 12, 1893; mother insane; history of onanism extending over a number of years. At the age of 17 he developed delusions of persecution; thought people induced boys to yell at and ridicule him on the streets; that his family persecuted him on account of his religious belief, he being an Episcopalian and they Methodists. He shortly became exalted and conceited; the ego of his arrogant nature soon obtained full sway; he concocted a scheme to form a new system of government, at the head of which he was to be God, and under him a certain Lucy was to be queen, his love and queen. On admission he was loquacious, communicative and restless. His restlessness was manifested by forcible actions, such as pressing his hands together, with all his strength, over his head and face; was in a state of extreme nervous excitement; when spoken to would jump as if a galvanic current had suddenly been applied to his spine, and became so embarrassed and confused that he could not gather himself sufficiently to answer the most simple questions. He remained in this condition until December, 1896, when he conceived the idea that if he were circumcised it would speed his recovery and invigorate him sexually, so that he would be able to propagate by the score. I circumcised him, and for awhile he improved, was

less nervous, gained in weight, and did good work in the dining-room. Later he became sexually excited, and was continually thinking of lewd women, as well as talking of them. The mere thought of a female would produce painful erections, and cause him intense pain and heat in the head; yet, were one to come within range of his vision, he would quickly escape from her presence, and, in all probability, behind the closed portal of his room, worship Onan, the god of his horizon. To what depth of mental degradation he has descended can be no better illustrated than by the following abstract, taken from a novel, as he termed it, written by himself a short time ago, which gives a fair description of his present mental status:

“LIFE OF A SCOUNDREL.

“The person who reads this history of my life will say: ‘He was a terrible case.’ I was born February 13, 1858. At the age of 12 I was a hard swearer; at 17 I burned the Bible; at 21 went to wine parties. I often dissipated until 12 o’clock at night. I seduced five young girls, and got into trouble by seducing a married woman. I tried forgery, and by it gained \$1000. I next tried burglary; by it I gained \$2000. I also tried the liquor business. I prayed to the devil; burned the Bible. I seduced a married woman, murdered her husband, cut up his body and fried it. I had a son. I instructed him to steal, rob, swear, get drunk, and lead a criminal life. I had the joy to see him die a drunkard, killed in a drunken row. I love crime and vice. I hate virtue. I hate purity. I desired to spread vice. In one year I gave away 11,000 obscene books and 8000 obscene pictures to young girls, to boys between 10 and 11, and to married people of both sexes. I tried to drive all desire and idea of virtue out of my mind. I sat up nights, praying to evil spirits, reading obscene and infidel books, practicing swearing, cursing God, and smoking. I started a big house of prostitution. I had 160 women and girls in it. I killed in one year 36 male and 24 female children. I hope the day will come when every church will be a house of prostitution, every girl of 20 a fallen woman, and every boy at the same age a hater of God and a swearer. ‘We must, if we succeed, corrupt the young,’ said I to my comrades.”

Young men who develop melancholia masturbatica are of a neurasthenic type, having been brought up by their parents and guardians in a strict moral and religious manner. These, after continued indulgence in this baneful practice, are smitten with shame and remorse; they try to conquer their abnormal desires, but, on account of the nervous exhaustion superinduced by it, they are made less able to resist, and fail. They need only to read the conspicuous signs and posters exhibited in the water-sections of hotels and saloons and on public sign-boards, relating to “lost manhood” and its consequences, which are gotten up by quacks and the lowest of vile humanity, who care

not whether they wreck the life of a man or his future happiness so long as it is attended with sordid gain, or to be told or believe their debasing practices are unclean in the sight of God, to throw them into a state of unbalanced mentality. The mind, under the unequal conflict between repulsive and degrading thoughts on one side, and high and nobler ones on the other, soon gives way to morbid ideas and actions. They believe they have committed the unpardonable sin, that they have transgressed against the laws of heaven and are therefore doomed to everlasting misery. These cases need careful nursing and treatment. On account of their warped judgment and inhibited reasoning powers they are prone to all sorts of dreadful and terrifying delusions, and attempts at suicide are not uncommon. Self-depreciation is one of the marked features of this form. Trivial shortcomings in earlier life assume gigantic proportions and add a heavier load to their already overburdened souls. One patient who had become greatly emaciated from refusing nourishment, and who was nearly exhausted from worry and loss of sleep, was prescribed massage, to be followed by an oil-rub. This he strenuously objected to, saying: "Don't bother with me; my rotten carcass is not worth it." One young man labored under the delusion that he was incurable, and that, after death, he would be barred from heaven because, when a small child, he cut off a lock of his sister's hair and slapped his younger brother. Another patient, a case of circular insanity, age 58, who had masturbated in early childhood, and who was just entering the depressive state of this form, wrote me the following letter:

"*My Dear Sir*: That I am past redemption there is no doubt. My privates seem to be paralyzed, and it is telling on me fearfully every day. Even God's spirit, what little I had left, has fled from me, and left me a worthless vagabond. What can be done or will be done with me I know not; but my secret sins have found me out. I am a disgrace to myself and people. Why should I let this Devil lead me along so blindly and bring me to an eternal home in hell? What the penalty for my crime is I know not, but I fully realize it is death on this earth. I had good, Christian advice given me in my younger days, but I did not heed it, and here have I brought up at the end of a sinful journey, to be consigned to a terrible and never-ending life of torture; but the laws of God are unchangeable. That there must be something done very soon there is no mistake; in my condition I am a disgrace to a lunatic asylum. It will be some relief to know my earthly fate at least. The disorganized organs are telling fast upon my appearance and physical condition. It cannot longer be concealed. It is an awful thing

to think of. If we could only realize the true sayings of the Bible in our younger days, what happy people we could be; but 'the wages of sin is death.' Every word of the Bible, from one end to the other, will be found true, without the disbelief of skeptics. Of course there is no use multiplying words any longer, as I think there will have to be something done very soon in my case. It is a horrible death to die and a horrible life to live.—S. L."

The physical state of melancholia is one of inanition. All bodily functions are retarded. The attitude is generally one of flexion and stationary. There is no inclination to stir or move about. The voice is weak and the enunciation is not clear. The eyes are fixed downward. Pulse is weak; respiration is shallow and subnormal, the heart is generally irritable, and the skin is harsh and dry. All secretions are diminished, and the general sensibility is much enfeebled. The appetite is poor and the breath has a starved odor to it, *i.e.*, like decayed animal matter. All movements are slow and weak, and continued insomnia and obstipation are always present.

A particularly interesting case was received at this hospital in December, 1897. He arrived with his neck encased in bandages, having attempted suicide a few days previous by cutting his throat with a razor. Family history is good; is 35 years of age and a machinist by trade. He had always lived an upright life, and was well thought of in the community in which he lived. He was associated with the Y. M. C. A., and was a devout and earnest worker in church and C. E. Society. No cause for such a deed could be given by his relatives and friends; his work was not considered confining or arduous enough to have occasioned such a condition. His family noticed nothing peculiar in his actions until two weeks previous to his attempt at suicide. He then first showed signs of mental aberration. His disposition was greatly altered; where formerly full of life, cheerful and bright, he became restless, depressed and very irrational. Imagined he had committed serious crimes and begged to have the district attorney prosecute him. Constantly asked to be forgiven, and when he thought that impossible, determined to make way with himself. On being questioned the patient stated he had been a confirmed masturbator for fifteen years past (undoubtedly exaggerated), and that he became sexually perverted two years ago. Under the influence of a man much older than himself

he became acquainted with and indulged in sodomy (this assertion is believed to be untrue; a thorough investigation made by his brother yielded nothing to substantiate it). These acts were kept up for a number of months without the knowledge that they were of a criminal nature. On being enlightened, he became impressed with the enormity of his evil doings, and profound depression followed; at the same time he tried to work harder to rid himself of his melancholy broodings, but to no avail. Six weeks previous to his coming here he was convinced of his utter worthlessness to humanity; thought his ill deeds were unpardonable and that he had sinned against redemption. He knew he had broken his country's laws; it being an unwritten one that men of strong passions and healthy bodies should marry. Physical examination showed him to be in very fair condition; heart and lungs were healthy. Skin dry; hands moist. Prepuce long and redundant. Tongue coated and bowels inactive. Temperature $99\frac{4}{5}$, pulse 124, respiration 26, weight 122 pounds. Was given *ignatia* *ic.* every two hours. December 6th, sleep deficient and irregular. Is very apprehensive, wants some one to write to the Governor to pardon him, as he knows he is to be electrocuted. Imagines he is to be put in jail, because the doctor who examined him and took his confession wore a striped shirt, which denoted prison garb. Eighteenth, dreams a good deal. Worries about his former life, can't seem to rid himself of the unpleasant memories associated with it. Says he was the means of causing the death of his father and mother (untrue), and deserves nothing but prison fare, bread and water. January 6, 1898, brighter this morning, trying to concentrate his mind on a magazine. Twenty-fourth, imagines that everyone is conversant with his past sinful career. Has lost all self-respect; melancholy. Rx. cobalt 3c, T. I. D. March 1st, weight 142 pounds. Visited by brother to-day; face wreathed in smiles for hours afterwards. Says he has over-estimated his wickedness and will try to stop worrying. June 6th, while out walking made his escape and returned home; brought back two days later. Thought he had done nothing wrong, and smiled when he told how he managed to get away. July, weight 160 pounds, slowly improving, showing better self-control. Is rather bright and cheerful, reads a great deal, attends all

amusements and is a willing worker. August, weight 173 pounds, fat and healthy, always smiling. Given a parole of the grounds, which he enjoys, riding a bicycle. Was discharged September 30, 1898, as recovered. Duration of disease, ten months.

One author says that the thoughts and feelings of melancholians are not favorable for the excitation of sexual desires, but that they, however, sometimes masturbate, the act being not so much due to a lustful desire as the anxiety to change, temporarily, the painful mental condition. This statement seems hardly credible, as cases of depression are in such a state of inactivity that they have not the ambition to change either their mental or their physical surroundings. It is probable that an hysterical state, in which all self-control is lost, is responsible for their indulgence in onanism, as in the case of the mental onanist, who is forced to masturbate to relieve the intense cerebral congestion caused by the constant dwelling on thoughts of a licentious nature. Very little literature, as yet, has been written on mental masturbation, although it has been noticed and spoken of for some time past. The term psychical onanism is supposed to have originated with Dr. Hufeland, of Germany, who speaks of it in his book, "*Makrobiotik*," as "*die geistige Onanie*." This form of onanism is more harmful in its effects than self-abuse. The enormous consumption of nervous energy which takes place has a very weakening effect on the mental activity of an individual, thus producing a most favorable soil for the subsequent development of dementia. Mental onanism is accomplished without any mechanical means, such as friction of the thighs, the genitals, etc., and is produced solely by excitation of the imagination. It is found generally to exist in persons who have previously practiced self-abuse and have given it up on account of fear or for moral reasons; or in those who, by continued excesses, have produced a more or less anæsthetic condition of the penis. In the case of the latter, the imagination is called more and more into play to complete the orgasm, until it eventually takes the place of the physical act.

Psychical onanism is always accompanied by an overheating of the brain tissue, which is occasioned by reading obscene or immoral literature, or bringing before the mind lascivious thoughts or pictures. In some instances the mental represen-

tation of sexual intercourse has produced such an increased state of sensual excitement that involuntary seminal emissions have ensued.

Dr. C. Spencer Kinney claims that "the class of masturbators found in every institution for the care and treatment of the nervous or insane embraces quite a number of what may be termed mental masturbators; those whose perversion of conscience is such that they may not yield to physical effort to accomplish their end, under the belief that it is wrong and a filthy habit, but whose thoughts are impure to the extent that no fair girl or woman comes within the horizon of their visual lives who does not produce more or less lasting thoughts of licentiousness. While no word may escape them showing to what depth their mental degradation has touched, yet they are in a rotten condition mentally. A pure, healthy thought is, to them, as impossible as pure air is to a confirmed cigarette smoker, and this depraved line of salacious thinking rots out the web and woof of every thread of their moral and intellectual existence."

The percentage of adolescent insanity is small. Some hospitals record as high as 14 per cent. of admissions; others report as low as 7 per cent. The dividing line between pubescent and adolescent insanities is difficult to appreciate. Pubescent makes its appearance at the time when the sexual organs first begin to develop; adolescent occurs at any time from the first beginning to the complete development of the reproductive organs and functions. Their symptoms are so closely allied, and their manifestations so analogous, that a description of one gives a very good picture of the other. Unfortunate heredity is the most important cause; it may be directly transmitted or skip one or more generations, springing up as a strong predisposition in the next.

Adolescent insanity begins either with an exaltation or a depression of spirits, sometimes the one following the other, with lucid intervals between. A prodromal stage of depression, restlessness, diminished activity and nervousness usually precedes the attack for a number of weeks; in it all interest in the ordinary pursuits and enjoyments of life is lost. There is such an aversion to social intercourse that they seclude themselves from their former friends and acquaintances.

At times there is an exaggerated emotional state associated with that of excessive well-being and importance. They are convinced of their superiority over mankind in general. They will brook no interference from others, are self-willed and fault-finding, and a source of care and anxiety to their parents; they order and try to intimidate and injure those about them—in fact, become conceited bullies. Filthy language, unreasonable demands and acts of petty tyranny are, to them, conclusive evidences of approaching maturity.

Maudlin sentimentality is occasionally indulged in. Young ladies whom they have scarcely met become the recipients of love-letters, stilted poetry and proposals of marriage. The adolescent does not think of such a thing as a barrier to his advances, believing that all women are in love with him and must yield to his demands. When the attack of acute mania comes on, these symptoms are intensified; they become violent and brutal in their actions; speech is rapid, foolish, incoherent, vulgar and blasphemous. Onanism is a generally accompanying symptom, and is quite a prognostic factor; the more it is practiced the less hope of recovery, and greater danger of termination in mental failure, chronic mania or paranoia. Ordinarily these attacks of excitement will last for a month, and after its subsidence the patient is left in a weakened, stupid and apathetic condition. During this stage they increase in weight and improve mentally. Just as it looks as if recovery might ensue, there follow other acute manifestations. The remitting of these symptoms continues until dementia is reached or a recovery is made, and is the most important diagnostic sign of this insanity. The depressive form of adolescent insanity does not differ essentially from other varieties of melancholia, except that the depression is not so profound.

The cases of two youths, which I now present, seem almost parallel. They are of the same age, both have light complexions and blue eyes, and the history of onanism in each is of long duration. Their temperaments are emotional, and a chain of religious exaltation, bordering on delirium, alternating with depression, ran throughout the whole course of their insanities.

CASE No. 4747.—Age, 16; no heredity. Admitted July 25, 1896, in a weakened physical condition; hands moist; skin

sallow; pupils contracted; tongue soft and coated white; had no appearance of comprehending his surroundings; is apathetic, dazed and stupid; unable to give any account of himself; quiet in manner; greatly depressed and confused; spoke slowly, and with reluctance; cannot recall recent events; thinks there are too many men who have something to do with him; cannot explain, except that they all dress differently. One week after admission became very emotional; masturbated excessively; at the same time cried in a plaintive voice: "There is but one God, my Jesus, and I am Thine!"* is continually muttering unintelligible sentences of a religious nature; stopped eating; allowed food to fall from his mouth when being fed; thought it poisoned. August 4th, slowly gaining; mind quite clear; recognizes every one; reads some; weak physically. 18th, religiously exalted. While masturbating to-day fell out of bed, striking on his back, without losing hold of his penis; continued masturbating; put in temporary restraint. From August 30th to October 1st had lucid intervals of short duration, when he would feel depressed and ashamed of himself; became quiet, and showed good self-control; would promise to stop masturbating, but no sooner was the promise given than it was broken; good intentions were cast aside, and were followed by outbreaks of mania, in which masturbation, mingled with religious excitement, would last for days. During one of these attacks he was visited by his mother. She had no more than entered the room when she became a target at which he spat and hurled vituperative epithets. In January, 1897, I circumcised him; marked improvement followed. He continued to improve, with slight relapses, until May, when discharged recovered.

No. 4696.—Admitted May 12, 1896. Age 16. Good family history. Had always taken an interest in religious matters. He worked himself up and worried a good deal over his spiritual welfare. Thought he was not as good as he might be. Kept aloof from other boys; their society was not congenial to him. Is apprehensive; fears if he makes any plans he will be disappointed. Says he was cross to his mother and struck her because she talked to him too much; supposes she did it for

* Why masturbation and religious excitement should be so closely associated in these cases has never been clearly demonstrated. Kraft-Ebing, in speaking of the psychology of sexual life, says that "the relation between sexual and religious feeling is shown on the basis of an unequivocal psycho-pathological condition, and, owing to the correspondence in many points between the emotional states when they are intense, the one may take the place of the other, or they may appear side by side."

his own good and in kindness, but he could not tolerate having his faults shown him. At times cries, although he appears satisfied here. Acts and looks like a masturbator. Restless and sleepless. January 1, 1897, went to the dance last evening and masturbated the whole night; observed by a room-mate. Nervous and hysterical this morning. Acting foolishly. Is suspicious; thinks his food is poisoned. Says there is no fun to be found in this institution except by masturbating. Twentieth, noisy and excited, striking himself in the face with fists; would not stop when told. Cursed and swore at patients and attendants without provocation. Twenty-fifth, restless, pulling his bed to pieces and winding the sheets around his neck. Tears his hair and bites the bedstead. July 1st, improving; acting with better self-control. Thirteenth, restless and annoying patients all day by his actions. Noisy most of the night. October, marked improvement. Doing well. January, 1897, continues slowly to improve. February 1st, better in every respect. Does not masturbate. April 1st, in good condition. Left on parole. May 1st, discharged recovered. Weight on admission, 133 pounds; on discharge, 176 pounds.

It is very interesting to note, in the insane, the various local symptoms which arise after indulgence in onanism, and by which this vice is afterwards detected. Some cases are very cross and irritable, and are unable to eat well for a number of meals; others are extremely annoying to other patients and their nurses by their meanness and unreasonable conduct. At times excitement follows and will last for a number of hours. One young man became flushed in the face and had dilated pupils; he would swear, curse and preach religion at the same time.

One patient, without a chill and any known cause, would have a sudden rise of temperature, reaching as high as 103 and 104°. It was accidentally discovered one day that this febrile condition came directly after an orgasm from self-abuse; another patient, suffering from acute mania, was very sly in concealing his acts; it was only when the orgasm took place that he was detected, at which time he gave vent to sounds which resembled the squealing of swine.

It does not seem plausible that cases of mental failure should be excessive in this vice. Yet I have observed that paretics and terminal dementes are the most intemperate. It is hard to say whether this habit is automatic, or is impelled by some

thought suggestive of lustful feeling. In this connection it may not be out of place to mention the case of a senile dement at this hospital, who, in his 89th year, has been detected in the act of masturbation, old age seeming to have interposed no barriers to his appetite for this vile habit.

The therapy of onanism is attended with varied success. Where the will-power has not become impaired to a pathological degree, we can look, as a rule, for favorable results. It would be far easier to treat the average case and the chances of recovery more certain, could we but have the grandparents of the present generation under our hands for treatment. It is beyond the power of a practitioner or specialist to counteract the results of heredity in each case. They are unable to supply new brains, neither are they capable of building up impaired nervous tissue sufficient to control the will of every individual: The first and most important step is to prevent the development of this vice. Therefore, too much care and attention cannot be given to its prophylaxis. In the very young particular attention must be given to cleanliness, and everything done in a hygienic way to allay or remove irritation; wet, soiled, or too tight clothing is to be avoided. The touching and fondling of the sexual organs by the nurse should be immediately followed by her dismissal. Skin diseases of the genitals or the flesh contiguous to them, such as eczema or scabies, should be promptly put under medical treatment, as the itching produced by them is often a sufficient cause. The bowels and bladder should be kept in healthy condition, and should a phymosis exist, it should be operated upon at an early date. Circumcision not only relieves irritation and makes it possible to keep the glans perfectly clean, but also lessens the chances of contracting venereal disease later in life. All children who are old enough should be sent to school, especially those of the poorer classes, whose parents are obliged to work out every day to obtain a livelihood, where they can be under the constant supervision of a teacher and kept out of mischief. When out of school they should be encouraged in healthful play and pastimes.

As the time of puberty approaches it is the imperative duty of those who have children in charge to inform them of the physiological changes which take place, and to warn them

against the sequelæ of masturbation. A sense of modesty or delicacy must not deter parents from carrying out such instructions; the future health and happiness of their offspring makes it too great a responsibility for them to shirk. Some believe that by informing the innocent young they attain a knowledge of a subject which was formerly unknown to them, producing a desire to investigate for themselves. Such a stand is foolish and unreasonable. In this present century of civilization, with its public educational institutions for the young, where all classes of society mingle together, it is safe to say that nine out of ten children will, sooner or later, learn of this evil, and under far more unfavorable circumstances than when informed by a good and solicitous parent. Great care should be exercised in the selection of reading matter for the adolescent; trashy, vulgar, immoral or suggestive literature should not be allowed to come into the house. A desire for good, wholesome and instructive books should be fostered in every home. It should be the aim of parents to make home life so attractive, so bright and interesting, that children will be attracted by the fireside, instead of securing amusement on the streets, where vice lurks in all forms, powerful enough to destroy their physical and moral lives.

Nervous and impressionable children should be kept away from strong religious excitement such as is exhibited in meetings of a revival nature. There is danger of their sensitive and emotional temperaments giving way under such a strain, mental disease resulting. If, as Kraft-Ebing states, there be such an intimate relationship between religious and sexual feelings, so that, under intense excitement, one takes the place of the other, there is danger of masturbation following a religious exaltation of spirits. That distinguished alienist, Dr. Selden H. Talcott, whose public utterances have attracted very wide attention both in this country and in Europe, in speaking of religious excitement as a cause of checked mental growth, says: "It may seem almost a sacrilege to some misguided enthusiasts to claim, just here, that an overzealous consideration of religious matters in early life is a sufficient cause for the imbecility in many cases. It is not the fault of religion that its precepts are sometimes presented to the young in such a manner as to shock the sensibilities, to inspire apprehension, and to instigate doubts

and fears and worryment in the untrained hearts and minds of youth. The blessed restraints of religion cannot be too highly appreciated, but the application of religious truths should be made in a simple, direct, clear, benign manner; otherwise the injury of profound shock, induced by fears of the future, may cause the budding powers of the young to wither before the fell influences of misguided and bigoted religious zeal."

To illustrate the effects of undue religious excitement, I cite the following case of a young man suffering from an incurable form of mental disease:

When a mere child, five years of age, he was taught by a boy in his father's house to play with his sexual organs. One day while drawing the prepuce back he was observed by his father, who did not chide or rebuke him; so he grew up, this habit fastening itself upon him without the knowledge of its harmful effects. At the age of 19 years he began attending Salvation Army meetings, which were being held in the town in which he lived. The first time it was curiosity that led him there. During the meeting one of the young lady members of the band came to him, knelt down and prayed for his conversion. That night his rest was disturbed, thinking over the events of the evening. The next night found him again at the barracks, when the same routine was gone over as on the previous evening, and was followed by more restlessness and less sleep. The third night one of the officers, this time a man, came and spoke to him, imploring him to seek Jesus. During the conversation with the Salvationist his knees began to tremble and he heard a voice, which he supposed to be that of some spirit, say to him: "It is the last chance your soul will ever have for salvation." He then gave way to his feelings and fell on his knees and tried to pray; later he was led to the platform, where he made a few inarticulate remarks. All that night he tossed in his bed, feeling more miserable than he had ever felt before, but at ten o'clock the following morning he said the Holy Ghost visited and sanctified him. Then he became so happy his joy knew no bounds. He sang and talked religion day and night; visited saloons and dens of vice, and prayed for their unfortunate victims and enjoined them to seek Christ. He tried, during all this time, to refrain from self-abuse, but was unable to exert any self-control. This exaltation was followed

by a depression of spirits and his subsequent commitment to this hospital.

If after, and in spite of all these preventive measures, this habit becomes formed, a rigid moral, medical and hygienic treatment should be carried out. Unless the patient repents of his practice and is anxious to get well, and will give his aid and hearty co-operation, all treatment will result in failure. It makes no difference how closely he is watched or how sharply rebuked, he will find ample opportunity to continue the indulgence. Where one is earnest in his desire to recover and will give up the habit, a favorable outcome is safe to predict. The victim of the vice should be kindly encouraged; new sports and interesting occupation should be found for him. His shortcomings should be pointed out and frankly commented upon. His future usefulness to the community should be impressed upon him; the more responsibilities of life he is able to assume, the greater becomes his pride and self-reliance. The nocturnal emissions which for a short time ensue after the discontinuance of the practice soon yield to remedies, supplemented by healthy outdoor exercise and a carefully prescribed diet.

In the weak-willed there is usually associated an enervated physical condition. This should be built up by tonics and strengthening food. Lots of milk, especially hot milk, should be given. Eggs whipped in milk will be found palatable and nourishing. Cold baths, needle baths, with alternating hot and cold sprays, are very stimulating in their effects. Sometimes a cold shower-bath is good for its moral effect; one case I call to mind ceased gradually to masturbate because of his great abhorrence for cold water. Turkish baths, where they can be borne, are also good. The introduction of cold water injections and cold sounds into the urethra are being used with beneficial results. They not only have a local stimulating effect, but act as a mental tonic. At the present time I am trying the effects of alternating hot and cold water urethral injections, but the cases have not been long enough under observation to make a report. Electricity does not seem to be indicated in the treatment of this class of patients, as its application is liable to produce an over-stimulation and heating of the sexual system. To increase the weight is of the greatest im-

portance. If flesh is added and the mental condition improves within a year, it is a favorable sign. Great increase in weight and no corresponding mental improvement warns us that dementia is approaching. Gentle but firm discipline should always be exercised.

Sexual intercourse with prostitutes should never be advised. Besides the immorality associated with it, there is danger of contracting syphilis, and, should marriage be afterwards consummated, great risk of its further transmission is involved. Should infection be escaped, I cannot see wherein their condition is benefited by such a liaison; orgasms are not diminished, and, of the two, sexual congress is the more powerful exhauster of mental strength. It is criminal to suggest marriage as a remedial agent. What man with the slightest degree or sense of honor would give his sister or daughter into the hands of such a degenerate for support and protection? A union of this kind is fraught with possibilities of danger that must not be overlooked. Think of the life a poor woman must lead, linked by the bonds of holy wedlock to a human being bereft of manhood, and of the future heredity has in store for their offspring. On the other hand, how does it improve the condition of the confirmed onanist? He is made miserable on account of the appetite for his former practice, which he seldom relinquishes after marriage; thus two lives are made wretched instead of one.

In the insane, in addition to other treatment, it is sometimes necessary to employ restraint. Some hospitals use leather muffs for the hands, while others use jackets with blind sleeves attached to their sides. To properly restrain patients, they should be put to bed in a hospital ward where their actions can be observed. In quiet patients, the tying of the wrists to the side-rods of the bed will answer the purpose, but in disturbed or excited cases, the camisole and protection-sheet should be resorted to. Iron cages have been tried at night to prevent seminal emissions during sleep, but are useless. This contrivance consists of two concentric rings, the inner one smooth, with apertures around its circumference, which lies against the organ in its relaxed condition; the outer one has spike-like projections which prick into the flesh through the holes in the inner ring at the time of an erection. Mechanical

irritation and operative procedures are in favor among a few. Blistering of the prepuce with nitrate of silver may deter them for a while, but the itching which follows only aggravates the condition.

Tuke cites a case where *actæum lyatte* was applied under the prepuce with good success; the habit was given up and the patient improved. Dr. Yellowlees rung the prepuce with silver wires like the snouts of swine. I doubt very much the good results of such a method, for I have known patients, immediately after circumcision, while the organ was inflamed and swollen, to masturbate, tearing every stitch asunder. Of all the operations I believe circumcision, when it is indicated, to be the best. From the observation of results in over one hundred cases on which I have operated, I believe a trial is justifiable. Not only in some cases is masturbation diminished, in a very few given up, but in a large number the irritability is lessened and the outbreaks of excitement become less intense. Resection of the pudic nerve has been followed by such negative results that a trial is not to be recommended. I do not place much reliance on castration. It does not always eliminate the sexual appetite; is a remedy that is tried after all others have failed and is only recommended in hopeless cases. At this time the mind has become so enfeebled that favorable results cannot follow. In the chronic insane all forms of restraint are useless; the best devices cannot stop them, as the rubbing of the legs against the penis or friction against the sheets accomplish the purpose. Even if they could be thoroughly restrained, mental onanism would take its place with just as evil results. In acute cases, where onanism is a symptom, restraint is recommended. As the patient grows better, the desire to masturbate becomes less frequent and the will-power is usually in control by the time recovery occurs.

Remedies are of secondary importance. A few of the drugs that have proven themselves efficacious are calc. carb., calc. phos., *cannabis indica*, *cantharis*, bell., *nux vom.*, *silicea*, phosphorus, phosphoric and picric acids, *ignatia*, *digitalis*, etc., the indications for which every well-informed homœopathic physician is familiar.

Parents whose lives are devoted to the welfare of their children, often through ignorance, overlook the most insidious

enemy lurking in the family fold. There can be no satisfactory excuse, however, among intelligent fathers and mothers, for the indifference shown by them to this hideous and persistent foe. It is too late, when their loved ones enter the portals of an insane asylum, to bewail a misfortune which they had both the opportunity and the power to prevent. It will be sad, indeed, if, in the life to come, we must answer for a soul that's wrecked by reason of our carelessness and neglect.

SOME PATHOGENETIC EFFECTS OF BORIC ACID.—Wild reports two cases of this character. In the first, the condition developed on three separate occasions following the administration of the drug. The patient finally died some time after the last attack in uræmia, following an alcoholic debauch; and in this connection attention is called to Fere's observations as to the influence of borax in hastening the onset of uræmia in patients with renal disease. The manifestations in the second case were similar to those in the first, and followed a prolonged administration of the drug.

Among 40 cases in which boric acid was administered and the results carefully watched, in one patient, a man aged 70, who was taking 80 grains in twenty-four hours, there was at the end of four weeks distinct flushing and redness of the skin, with the appearance of slight albuminuria. The urine was normal before the acid was given, and albumin disappeared two weeks after its discontinuance.

Wild, on one occasion, took 120 grains of boric acid within four hours. He suffered from nausea without vomiting, colicky pains in the abdomen followed by diarrhœa seven hours after the first dose, which continued for some hours. On the next day he experienced slight headache, a feeling of depression, a want of appetite and marked flushing of the skin. The urine contained free boric acid, which first appeared four hours after the drug had been taken and persisted for twenty-six hours. It was also discovered by experimentation that a certain portion of the acid was converted into sodium borate and excreted in that form.

A review of the recorded cases of poisoning from boric acid and borax shows that two forms must be distinguished. In the first, a large quantity of the drug is absorbed rapidly from the alimentary canal, from some serous or other cavity, or from an extensive raw surface, causing vomiting, diarrhœa, general depression, skin rashes, and partial paralysis of the nervous and muscular systems causing death. In the second form, the drug has been administered in comparatively small doses for long periods. In some of these cases the kidneys are diseased, in others albumin appears in the urine, and in several fatal cases uræmic symptoms were described.—*Lancet*, January 7, 1899.

[The writer recalls an instance in which the administration of 5 grains of boric acid three times a day, in connection with daily flushing of the bladder with boric acid solutions, produced a general flushing of the skin, followed by a profuse fine desquamation. The patient, a man of 70, had a marked cystitis, but the urine presented no evidence of nephritis.—F. M. L.]

EDITORIAL.

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ABSIT OMEN.

A MONTH or two ago one of our Western journals presented a jeremiad on the apparent decadence of the homœopathic schools of the present day, and the dangers which threaten Homœopathy, as manifested in the departure from pure homœopathic practice and the borrowing of methods and remedies from the allopathic school; in the defection to the enemy of physicians of our school, and in the taking of post-graduate courses in old-school colleges by our own graduates.

The paper was quoted largely by a New York contemporary, and was used to show that its own wishes and predictions were in a fair way to be realized, viz., that Homœopathy as a distinct method of practice was going to the "demnition bow wows," and that it was high time for all self-respecting practitioners to throw aside their sectarian designation, and, simply as physicians ("at large" shall we say?), join the ranks of that branch of the profession which has always shown itself so liberal and tolerant, and—to practice as they please. (Of course we omit here the usual "fool or knave" business as not to the point, this time.)

We would gladly sink our souls in the beatific vision of the gay but not gaudy millenium thus conjured up, but it would hardly prove profitable; let us rather examine the grounds given for assuming that Homœopathy is rapidly approaching its last ditch, and that its colors will soon be found only in that vast museum where hang the emblems of the numerous theories which have fought, bled and died on the field of so-called rational medicine.

1. The departure from the practice of Homœopathy as originally taught by Hahnemann. We insist here again, as always, upon a distinction being made between Homœopathy and Hahnemannianism. That some departure from the latter would become necessary in the development of the former was

to be expected, else would Homœopathy be deserving of rejection by all who have even a slight acquaintance with the discoveries made in the sciences auxiliary to that of medicine. We do confess, however, with sorrow, that the gross departures from homœopathic principles, too frequently apparent in the practice of physicians calling themselves homœopathic, are an opprobrium to Homœopathy; but does this prove anything against the truth of the system? Only if it can be shown that such departures are the consequence of the failure of Homœopathy after a careful and conscientious application of its principles. Can this be shown? We think not. Very many of the un- and anti-homœopathic practices are only the natural and logical results of a rational limitation of the sphere and justifiable scope of Homœopathy. Where this is not the case, want of careful, painstaking study of and acquaintance with our *materia medica* on the part of the younger members of the profession, educated in the midst of the present reactionary period through which our colleges are passing, combined with a desire for brilliant and immediate results, will explain their occurrence without furnishing any plausible argument against the truth of Homœopathy.

2. The defection of some of the members of our branch of the medical profession. It is true that some "local celebrities," perhaps, and others neither locally nor otherwise celebrated, have been reported as having gone over to the enemy, but again the same argument holds good, with even greater force. If, after several or many years of successful practice of Homœopathy, the proofs of which have been duly heralded in our journals and before our societies, one or another physician declares it was all a delusion and a snare, that he was mistaken and that he now sees the error of his ways, will we be disposed to place any great reliance upon his skill or his judgment? Hardly. If he was not able in the past to know when or whether he cured, can we suppose him to have been able to practice Homœopathy as it should have been practiced? Can he be regarded as a fit judge of the merits of Homœopathy? If he then deceived himself and the public, may he not now be deceiving the public and himself? Is it not that he was then either a fool or a knave, and now either a knave or a fool?

3. The taking by our graduates of post-graduate courses in

old-school colleges. In the past, the necessity really existed for such action by all those who wished to cultivate the purely scientific side of medicine, or even for those who wished to receive practical instruction in the specialties. We acknowledge that until within late years our colleges did not afford opportunities equal to those offered in allopathic schools, and even at the present time some of their auxiliary departments are better equipped than our own, by reason of their longer existence and more abundant resources. No doubt many of our graduates, building their expectations upon the reminiscences of their preceptors, think to find elsewhere the advantages which these latter had not found with us. But times have changed and we have changed with them, and there is but little to be found in allopathic colleges which cannot be acquired equally as well in homœopathic ones. If we come to inquire into the motives which have prompted some of our graduates to seek an extra polish elsewhere, we will be surprised to find how little it has had to do with any supposed insufficiency in the course of instruction which they have received, and how it is rather the result of a desire to obtain a diploma from some allopathic institution which they presume is better known to the general public than their alma mater. Such diploma will also put it into their power incidentally to refer to the fact that they have graduated in both schools, and are, therefore, capable of practicing either way. You pay your money and take your choice. In some localities this broad (?) base may prove a good foundation upon which to build a good mixed practice, and so long as public and physician are satisfied why need Homœopathy care? But surely a recent graduate can hardly be held up as a very competent authority as to the sufficiency or insufficiency of Homœopathy, or in fact of anything, except, perhaps, of his own capabilities and potentialities. His prudent course, therefore, can be no argument either against Homœopathy itself nor against it as taught. If it were of frequent occurrence it might prove a source of danger to the purity of Homœopathy, and might eventually so corrupt the mass of physicians as to blind them to the essential differences existing between the two methods of practice, and make them willing to be quietly swallowed up in the capacious maw of traditional Medicine (with a big M).

We maintain, therefore, that the above circumstances have not the remotest logical bearing upon the question of the truth of Homœopathy, but they do constitute obstacles in the way of its legitimate development. What is the remedy? We can see but one, and that lies in the hands of our colleges. They are homœopathic colleges, and unless they intend to teach Homœopathy they are superfluous; unless they do it they are frauds. They *may* teach any and everything else, but they *must* teach Homœopathy. Therefore that subject should, as much as possible, be made to pervade the atmosphere of our colleges, hospitals, clinics and dispensaries. All other means and appliances in the treatment of disease may and must be used, but as adjuvants, accessories, to the homœopathic treatment, where such is at all applicable. This course implies no more hypocrisy than, while ostensibly teaching Homœopathy, to suggest its inefficacy by its non-employment. We regard the conditions at present existing in our colleges as necessarily incidental to the stage of evolution through which they are passing, and out of which, by sober, conservative, but, at the same time, progressive counsels, they will emerge as the staunchest bulwarks of the future science of Homœopathy.

INTESTINAL HÆMORRHAGES IN HYSTERIA.—Dr. Mouzon calls attention to the recognized fact that hysterics may present the most different sets of symptoms which may simulate serious diseases and lesions. Cases of seemingly grave inflammatory joint diseases or of pseudo-appendicitis where surgical operations have been done have been described in the literature. Similarly is it with sweating, spitting and vomiting of blood in hysterics. Mouzon details three cases where hæmorrhage from the intestines occurred with associated symptoms which pointed to a serious intestinal disease. There were violent colicky pains, great sensitiveness of the abdomen, and a collapsic state which gave rise to apprehension. However, the presence of hysteric symptoms, the absence of fever, the lack of a plausible cause of the symptoms, as well as the good results from the bromine compounds, led to a recognition of hysteria as at the bottom of things. There first appeared a sense of distress, with pain in the bowels, sacrum and loins. The rectal hæmorrhage was never great, and lasted from twenty-four to thirty six hours. The blood was always bright red and never mixed with the fæces. The differential diagnosis was easy in cases where other hysteric symptoms were obtainable. In one case it was difficult on account of cutaneous hyperesthesia and anesthesia being the only hysteric signs present. Cold compresses to the abdomen, astringent rectal injections and bromine preparations are the therapeutic measures which he recommends.

GLEANINGS.

PULMONARY TUBERCULOSIS IN OLD PERSONS.—Dr. Crespin calls attention to the torpid reaction of the organism in tuberculosis of the lungs in old persons, they being often affected with chronic bronchitis and emphysema, while microscopic examination of the sputa may be negative. The signs of auscultation and percussion are those of chronic bronchitis and emphysema. Sweating, fever and hæmoptysis are often rare, though frequent and abundant hæmoptysis has been noted, chronicity, slight intensity of symptoms, and anatomically a decided tendency to sclerosis-fibroid phthisis. In many cases there is an associated arterio-sclerosis, with an increased tension of pulse. *La Semaine Medicale*, No. 12, 1898.

TWO CASES OF NEPHRITIS COMPLICATING ACUTE ARTICULAR RHEUMATISM.—Dr. P. Lemanski, in two cases of acute articular rheumatism, after a few days observed an uræmic attack suddenly to develop with convulsions, headache, nausea, vomiting, arrhythmia, etc.—in fact the whole classical syndrome—accompanied by abundant uræmia in the first and a moderate albuminuria in the second. Both patients were placed on an absolute milk diet, with salicylates in large doses. They both recovered completely. Intense headache and arrhythmia are premonitory signs.—*Le Bulletin Medical*, No. 42, 1898.

PREMATURE OLD AGE.—Dr. Donner, of Stuttgart, states that for a number of years he has met with a series of patients where a diagnosis of neurasthenia had been made either by himself or other physicians. Their complaints were of a varying nature. They complained of poor appetite, slow digestion, insufficient passages, a weak heart, palpitation, and distressed breathing on the least exertion. The daily work, which formerly was easily done, now was difficult, disagreeable, and the friends complained that they were indifferent to everything more or less. Some suffered from an empty feeling in the head, weakness of memory, and lack of confidence in one's self. Decisions in business and other affairs which formerly were easy now were the cause of much distress and irritation, and caused them to seek advice of this or that acquaintance. What was most noticeable was that they were all exhausted of nights, and persons who formerly went out every evening, and were jovial companions, now could scarcely await the hour when they were to go to bed. And yet in the majority the sleep was poor; scarcely had they fallen asleep than they woke up and could not go to sleep again, for all possible thoughts would crowd upon them, and they would think over and recall the happenings of the day past, and put them in an unfavorable light. Thus they would lie for hours in bed, and on the following morning they would awaken more tired and relaxed than the evening before. A weakening of the sexual functions and of the bladder would be complained of; the stream of

urine would be without energy, and they would be obliged to wait a long time before starting the water. The urine, which was frequently examined, as some feared Bright's or diabetes, was found to be normal, excepting an excess of urates and phosphates. They would complain of their legs being without strength, so that climbing stairs or a walk of half an hour was especially tiresome; dull pains in the knees, and a sensation of coldness and numbness of the feet. The majority of these patients ranged from thirty to fifty years of age, and there were twice as many men as women. A diagnosis in these cases was difficult, for beyond a slight weakness of the heart, absolutely nothing abnormal was detectible. So he was forced to fall back on his earlier diagnosis of neurasthenia, and, prescribing according to similia, he obtained improvement, but no cure, and the patients passed over into other hands, where the same thing was gone through again. An article in the *British Journal of Physiology*, by a Dr. Hodge, led him into the right track, for here there were a number of very similar cases. He attributed the symptoms to a premature ageing of the body, due to a degeneration of certain stellate cells (neurons) in single parts of the brain where the neuroglia had increased until the whole cell was compressed and softened. However, this required much time, and there were chances of a recovery in many cases. In these cases there will be found a history of neuropathic entailment: the father had died early of consumption, the mother was hysteric, eccentric, nervous, and possibly passed years in an asylum, while a brother or sister was melancholic, nervous, hysteric, eccentric, and addicted to drink, or ended by suicide.

The homœopathic materia medicas did not help him much as to therapeutics, but Kobert's work on Poisons led to select arsenicum, phosphorus and plumbum as the three drugs which would bring about a similar degenerative condition of these cerebral cells. And, indeed, with these remedies he has succeeded in restoring many to their families and occupations who would have been irretrievably lost without treatment. Time and patience are necessary in these cases. The medium and higher attenuations were employed. Daily galvanization of the head according to Althaus was very useful, for a noticeable improvement would rapidly be noted even in two or three weeks.—*Homœopathische Monatsblätter*, No. 3, 1899.

SULPHUR SALVE IN SQUAMOUS BLEPHARITIS.—Dr. Terson, of Paris, in squamous blepharitis, which is usually associated with the same condition of the hairy scalp, advises local application of a salve of sulphur, 1.20, in vaseline. Small crusts detach themselves from the palpebral borders of the lids, yet there are no ulcers or abscesses of the ciliary follicles. In this form of blepharitis all the topical agents which act well in other forms produce irritation even to ulceration. He has employed the sulphur salve for years and thinks it deserving of extended use.—*Journal des Practiciens*, No. 12, 1898.

OPERATIVE MEASURES IN CRUSHING INJURIES OF THE KIDNEYS.—Dr. Nasse, of Berlin, recently presented before the Berlin Medical Society a boy in whom a nephrectomy was done for a crushed kidney from a fall during "turning." He was transferred to the hospital on account of a severe anæmia following hæmaturia. In the right lumbar region there was increased resistance and an augmented area of dulness. Six days after he retained his urine while the bladder was distended with blood-clots. Catheterization with-

drew no fluid nor urine. Collapse was apparent. A great mass of clots was aspirated from the bladder through the urethra and an operation done.

The kidney was found imbedded in a bloody sac, which, after being opened and evacuated, was followed by violent hæmorrhage, which was controlled by tamponade. The kidney, crushed through in the middle, was extirpated. A recovery followed. Only since 1889 has there been a tendency to adopt active operative interference in hæmaturia from simple, uncomplicated crushing laceration of the kidney. As to the lesions, several groups may be differentiated. At times the hæmorrhage is extremely violent at first, a hæmatoma forms in the region of the kidney, and death occurs within twenty-four hours from extreme acute anæmia. Usually, however, the course is slower and more intermittent; yet even here death may take place from anæmia. In still other cases, with a favorable commencing course, a violent hæmorrhage rapidly ends fatally. In the first group energetic measures are required, yet one should differentiate sharply between shock and anæmia. The third group also necessitates immediate operation. In the second group the question of operative measures is difficult, as these cases tend spontaneously towards recovery. If the hæmorrhages recur frequently, then the anæmia becomes dangerous and an operation is called for. In slight laceration tamponade or suture suffices, but in extensive disintegration of renal tissue then extirpation is our only recourse.—*Deutsche Medizinische Wochenschrift*, No. 33, 1898.—Prof. Nasse, a brilliant surgeon of Berlin, recently perished by falling into a fissure in a glacier, during an Alpine tour.

TREATMENT OF TUBERCULOUS ABSCESES.—Prof. Lannelongue, in the management of tuberculous abscesses, calls attention to the difficulty of extirpating all the affected tissue and the danger of evacuation with following curetting on account of general systemic infection, and therefore he advises evacuation with a trocar of good calibre, careful irrigation of the cavity with a 1 per cent. solution of carbolic acid until the fluid returns clear, and the injection with a solution containing iodoform, of which he has found the following to give excellent results: Iodoform; sulphuric ether, aa. 10.0; creasote, 2.0; sterilized sweet almond oil, 90.0. Of this mixture 30 grammes, almost an ounce, and corresponding to 2 to 3 grammes of iodoform, are usually injected. No toxic symptoms were ever observed. Of seventeen patients, four were cured by a single injection, three after two, three after four, one after five, and in the others fistulas formed which required a longer time. The presence of a mixed infection is no contraindication. At the same time general measures, with plenty of fresh air, should not be neglected.—*Wiener Medizinische Presse*, No. 10, 1899.

A MOMENTARY CONTRAINDICATION FOR VACCINATION.—Dr. Saint-Yves Ménard states that though in times of an epidemic of small-pox all children as well as adults should be vaccinated, yet in those with eczema of the scalp, both dry and moist, vaccination should not be done until the skin disease is cured, for secondary pustules may form in the eczematous spots, and also vaccination may determine another outbreak of eczema. If it be necessary to vaccinate such subjects, then select a healthy spot of skin, make only one puncture, and keep it covered well.—*La Settimana Medica*, No. 8, 1899.

TWO CASES OF CONGENITAL SYPHILIS.—Prof. Haslund, of Copenhagen, reported to the Danish Dermatological Society two interesting cases of hereditary syphilis.

1. The child, a boy of 6 years and 9 months, whose father and mother had had syphilis, but whether he had been treated for it the mother did not know. After the birth of this child she had red spots on her body and her hair fell off, while she suffered from a long-lasting headache. She had borne four children—the first time eleven years ago. This child died when fourteen days old; the others are alive. Two abortions later. This patient was said to have been healthy the whole time, but he had an eye disease which lasted a year. There were no signs of a cicatrix on the eye. This present trouble he has had for a year. On the left leg there is a growth of the size of a walnut, tender and elastic, but with a normal and displaceable skin covering it. Otherwise, nothing. He is pale and not undersized for his age.

2. The second patient was a boy of 10 years, who, when six years old, had a general eruption and had been treated with a blackish powder. One month ago his disease began in the right eye; later, in the left. He has the notched teeth of hereditary syphilis—Hutchinson's teeth. His hearing is not good, but he had adenoid vegetations in the naso-pharynx.

In this latter patient there was merely a new outbreak of his congenital syphilis, which seemed to be of a moderate degree in spite of both parents having had syphilis. In the first patient it might appear as if late hereditary syphilis were in question, though it is impossible to determine whether milder and untreated attacks have not preceded this one.—*Hospitalstidende*, No. 7, 1899.

HEADACHES IN CONSEQUENCE OF EYE DISEASES.—Dr. A. Peters is of the opinion that the majority of headaches dependent on ocular disturbances are true supraorbital neuralgias, though he admits that in long-lasting cases the dura mater may be involved through the ramus recurrens. These pains are especially brought about by functional disturbances. First of all in importance is hyperopia with concomitant astigmatism, which is capable of producing migraine-like attacks. Further, there are disturbances of the external eye-muscles which may lead to asthenopic symptoms and headaches. Insufficiency of the internal recti muscles is especially prone to this. Besides, acute inflammations of the globe of the eye may cause radiation of the pain into the head. Finally, there are two causes of asthenopic difficulties which are but little recognized: 1. Conjunctivitis sicca; and, 2. Conjunctivitis due to the diplobacillus, which has been studied by Axenfeld, Morax and the writer. Therefore he thinks that treatment of the conjunctival disturbances and associated symptoms should occupy an important place, for they may give rise both to supraorbital neuralgias and headaches more frequently than is generally supposed.—*Berliner Klinische Wochenschrift*, No. 10, 1899.

RENAL TYPHOID FEVER.—Dr. Rostoski describes two cases of typhus renalis from Leube's clinic in Wuerzburg. The chief symptoms were a hæmorrhagic nephritis with fever, and quite pronounced confusion of the senses; the intestinal signs were but little pronounced or absent. The diagnosis was made from the enlarged spleen, the diazo- and Widal's reaction. In one, typhoid bacilli were obtained in a pure culture from the urine. In those cases of hæmorrhage which appear as seeming idiopathic nephritis with high temperature, he advises bacteriological examination of the urine, and application of Widal's reaction, for a renal typhoid may be present.—*Muenchener Medicinische Wochenschrift*, No. 7, 1899.

FRANK H. PRITCHARD, M.D.

ALCOHOL AS AN ANTIDOTE FOR EXTERNAL CARBOLIC-ACID POISONING.—Dr. Seneca D. Powell, of New York, has for a long time used in his clinics at the Post-Graduate Hospital an antidote that we have all come to recognize as a specific. I allude to alcohol; and it is not an unusual occurrence to see Dr. Powell, in the presence of his class, catch in his open hands a quantity of pure carbolic acid poured into them by a nurse from a bottle. In a few moments the doctor puts his hands into a basin of pure alcohol, and no escharotic effect is observed whatever from the action of the carbolic acid upon the skin. I was somewhat surprised when I saw this first experiment, but when I recognized the result I was convinced of the scientific fact. At the present time we are flushing out abscess cavities with pure carbolic acid and washing them out a few minutes later with pure alcohol. In empyema Dr. Powell, after making a large opening in the chest wall, washes out the cavity with a ten per cent. solution of carbolic acid, after which pure alcohol is used, and no bad effect has been observed from this treatment. The cavity of the pleura is rendered aseptic. From personal observations and demonstrations in the use of pure carbolic acid followed by the use of alcohol, I can state to the profession positively that we have in alcohol an absolutely safe and sure specific against the escharotic action of pure carbolic acid. And I believe this fact should be given wide publicity to the profession, and even to the laity, because in cases of carbolic poisoning with homicidal intent, if, immediately after the administration of the poison, alcohol was thrown into the stomach of the individual, the poisonous effect of carbolic acid would be at once neutralized. However, as to the subsequent constitutional effect from the absorption of the new compound formed I cannot speak, but certainly in all cases of local carbolic acid poisoning, particularly in such a case as that mentioned by Dr. Weiss, I have found that alcohol is an absolute, powerful and immediate specific.—A. M. PHELPS, M.D., *New York Medical Journal*, Jan. 14, 1899.

F. WALTER BRIERLY, M.D.

THE INFLUENCE OF THE ERYSIPELAS-PRODIGIOSUS TOXINS UPON MALIGNANT GROWTHS.—The April number of the *Practitioner* is devoted exclusively to the consideration of "cancer." In discussing the treatment of inoperable carcinoma, Coley offers the following conclusions as to the injection of the mixed toxins of erysipelas and bacillus prodigiosus:

1. The mixed toxins of erysipelas and bacillus prodigiosus have an inhibitory action upon the growth of malignant tumors of whatever variety.
2. This influence is far more marked upon sarcoma than upon carcinoma, and differs markedly in the different varieties of sarcoma, being most pronounced in the spindle-celled variety, and least in the melanotic.
3. A considerable number of inoperable sarcomata, the correctness of the diagnosis of which is beyond question, have entirely disappeared under this method of treatment.
4. A large proportion of these cases have remained free from recurrence after more than three years.
5. The action of the toxins upon sarcoma must be regarded as a rapidly progressing necrobiosis, with fatty degeneration, and it seems to be rather specific in character.
6. This method of treatment is attended with some risk—as from collapse from the use of too large a dose, and from pyemia from septic infection—unless certain precautions are taken.

7. The use of small doses of the toxins for a short time after primary operation has much to commend it, theoretically, as a prophylactic measure.

8. The action of the toxins upon sarcoma is in strict accord with the known action of the living streptococcus of erysipelas.

9. The toxins, to be of value, must be prepared from highly virulent cultures of the streptococcus.

CONCLUSIONS AS TO THE VALUE OF THE WIDAL REACTION IN TYPHOID FEVER.—Anders and McFarland summarize their conclusions, as follows:

1. The disease is not to be excluded on account of the absence of a positive Widal reaction, since genuine cases have been met with in which a negative result had been obtained throughout.

2. All cases that react positively are to be regarded as typhoid fever, until a thorough bacteriologic examination fails to reveal typhoid bacilli anywhere in the body, as cases occur in which the usual enteric lesions are entirely wanting.

3. Taken singly, the sero-reaction is the most trustworthy indication of typhoid fever.

4. Although not an early diagnostic symptom, it nevertheless serves to complete the diagnosis in the great majority of cases at the earliest date possible.

5. Since the sero-reaction may be long delayed, and very exceptionally absent throughout, it cannot be solely relied upon for therapeutic purposes.

6. Previous attacks of typhoid fever, within one, two or three years, render the test valueless.

7. In order to secure accurate results, the technic is to be carried forward by a trained bacteriologist.—*Phila. Med. Journal*, April 15, 1899.

F. MORTIMER LAWRENCE, M.D.

SIMULTANEOUS BLOOD-WASHING AND BLOOD-LETTING IN URÆMIA.—A. B. Knowlton, M.D., Columbia, S. C., in a paper read before the Tri-State Medical Society of the Carolinas and Virginia, at Charlotte, N. C., called its attention to the *combined* or *simultaneous* practice of blood-washing and blood-letting, and reported the following cases:

CASE I.—On November 16, 1897, I was called to Mrs. P., who had passed through a normal labor the day before, having given birth to a healthy full-term child, and who had been in convulsions for two hours. In addition to the usual treatment, normal salt solution (three pints) were injected into the right median basilic vein, and at the same time about twenty-two ounces of blood were drawn from the left temporal artery. The patient rallied somewhat, but did not regain complete consciousness, dying in three hours after my arrival.

CASE II.—On April 15, 1898, I was called to Maggie P., colored, who was in the eighth month of pregnancy, and had had four convulsions of increasing intensity during the two preceding hours. I injected three pints of normal salt solution into the right arm, and simultaneously bled about twenty ounces from the left. No other treatment was given. In half an hour after the injection and bleeding, the patient had one convulsion, which was said by the women present to be much lighter than any of the others. In six hours more she had another convulsion, which was even still lighter, and amounted only to a slight tremor. In the meantime the patient became conscious and

called for nourishment. In eight hours more (fourteen hours since the bleeding and injection) I dilated the cervix under chloroform and delivered the child. The woman had no more convulsions and made a good recovery.

CASE III.—August 10, 1898, Mr. A. had been in uræmic coma for seventeen hours when I arrived. I immediately bled about twenty-five ounces from the left arm and injected about four pints of salt solution into the right. I repeated the injection (about a quart) in an hour. Patient gradually responded to reflex tests, and in about three hours was conscious. Two more quarts of saline injection given on next day. Patient made a good recovery, though urine still showed some albumin, and feet occasionally œdematous.—*Charlotte Medical Journal*, February, 1899. W. D. CARTER, M.D.

SURGICAL HINTS.—Never allow a room to be swept or dusted just before an operation. Cover everything with wet sheets, if necessary, so as to prevent the raising of dust.

When you have blood upon your hands, first wash them in pure water. Using soap is a mistake, as soapy water does not dissolve blood rapidly. Clear water and a nail brush should come first, soap next.

In all amputations, remember that the loose muscles retract more than those which are attached to the bone. Hence it is better to sever the loose muscles first, and the attached ones next, so that the ends may be of equal length.

If you believe that your operation has been a clean one, leave the wound alone if not an infected one. The best surgeons usually apply but one dressing, the first. When this is removed the stitches are taken out, and the wound only needs a clean covering for a few days.

Before giving ether to patients suffering from catarrh of the nasal passages, wash these out with an alkaline solution. This will, by cleaning out the secretions, allow much easier breathing, and hence increase the facility with which anæsthesia can be induced.

Scalp wounds should always be stitched if of any size. But always remove the stitches very early; otherwise they may act as setons, and lead to suppuration, which, if it reaches the loose layer under the aponeurosis, is likely to be serious. These wounds only gape if the scalp muscle or its aponeurosis is incised, and very few stitches are needed.

In cases of felon, find out as soon as possible whether the bone is attacked. Should the terminal phalanx become loose, amputation will nearly always give the most useful finger, especially to workmen. The amputation is best delayed until the septic process is overcome, or else the flaps will probably die, and the time needed for healing by granulation will be greater than that taken up in previous antiseptic treatment.

In bad cases of frost bite of the hands or feet, do not be in a hurry to amputate. Rest in bed and the most careful asepsis will often allow you to save fingers and toes that would be sacrificed otherwise. The asepsis must be thorough; shreds of necrosing tissue must be duly removed, and the patient's strength upheld by careful nutrition. Under such conditions, if gangrene becomes established, it is usually found that the line of demarcation is much further towards the extremity than was anticipated.—*International Journal of Surgery*, January, 1899.

INTESTINAL OBSTRUCTION.—In the discussion of this subject before the Southern Surgical and Gynæcological Association, Dr. Wiggin, of New York,

gave the following as the various conditions for which operations are usually demanded. (1) Strangulation of the gut by bands, extensive adhesions or apertures; (2) volvulus; (3) intussusception; (4) obstructions due to neoplasms; (5) compression by tumors external to the gut; (6) obstruction from foreign bodies, as gall-stones and enteroliths; and (7) obstruction caused by faecal masses.

In acute cases there is little time for preparation. Loose furniture should be removed from the room and the floor covered with sheets wet with a strong antiseptic solution. Instruments should be boiled in a two-per-cent. soda solution, towels sterilized by boiling, and a wash boiler of water boiled and rapidly cooled in pitchers packed in ice. The patient anæsthetized, the field of operation should be successively treated with the following: (1) Green soap; (2) hydrogen dioxide; (3) lathered and shaved; (4) water; (5) equal parts of alcohol and ether; (6) 1-500 bichloride solution in alcohol; and (7) sterile water or saline solution. Incision should be through the rectus muscle. Distended coils of intestine should be aspirated or incised, and the wounds so made closed by suture and the parts cleansed with hydrogen dioxide. The collapsed portion of the bowel should be found and followed to the seat of obstruction. The various hernial orifices should be examined, remembering that sometimes two forms of obstruction may coexist.

In closing, Dr. Wiggin laid great emphasis on the fact that the prognosis in this class of cases depends more upon the promptness with which surgical interference is instituted than upon any other factor.—*Atlanta Medical and Surgical Journal*, January, 1899.

THE PREVENTION OF DEFORMITY AFTER EXCISION OF THE KNEE IN CHILDREN.—Dr. Wisner R. Townsend, in a paper read before the Orthopædic Section of the New York Academy of Medicine, quoted from the standard text-books and cited a number of cases illustrating the above topic. He draws the following conclusions as the result of his experience:

1. Excision of the knee should rarely be performed before puberty.
2. Erasion, arthrectomy, or partial operations are to be preferred.
3. Shortening will usually follow, and depends on the amount of bone removed and the age when the operation was done.
4. Protection should be given the knee for a long time after the operation to prevent flexion, knock-knee, genu recurvatum, bow-leg, and other deformities.
5. Always put the leg up straight.
6. In severe septic cases amputation is preferable to excision.—*New York Medical Journal*, April 1, 1899.

ABDOMINAL SECTION UNDER COCAINE ANÆSTHESIA.—In the *Cleveland Medical Gazette* for February, Dr. Hunter Robb reports a case of this kind. The general condition of the patient would not permit the use of a general anæsthetic, and the symptoms from a markedly retroposed and adherent uterus seemed to demand surgical interference. Eight minims of a five-per-cent. solution of cocaine were injected under the skin in the median line, and eight more into the muscles. The peritoneal cavity was opened, the adhesions of the uterus broken up without any apparent discomfort to the patient. The uterus was then brought forward and stitched according to the ordinary suspension method.

F. WALTER BRIERLY, M.D.

THE COMPLICATIONS OF PREGNANCY, LABOR AND THE PUERPERAL PERIOD WITH CHRONIC HEART DISEASE.—The majority of authors agree that any considerable hypertrophy of the heart does not occur in pregnancy. A sound heart easily overcomes the increased demands of pregnancy and labor. A diseased heart is subject to serious disturbances. The most important thing to determine is whether the heart is compensated or not. A woman who becomes gravid with non-compensated valvular disease has little outlook for safe pregnancy, labor and puerperium. If the failure is compensated and the heart muscle remains sound the conditions are favorable, so long as there are no complications, as nephritis, bronchitis, endocarditis recens, etc. An absolutely good prognosis should never be given in any chronic heart failure in pregnancy. The danger in primipara is not so great as in multipara. It is important to recognize a high degree of failure, or if one or several valves are diseased. Mitral stenosis is especially dangerous. Among the complications diseases of the respiratory organs are especially to be feared. The prognosis for the child is not good, as women suffering from heart disease incline to abortion and premature labor. Maidens with non-compensated heart disease should not marry. Women who have already survived a severe labor should remain sterile.

Pregnant women suffering from heart disease should guard against physical exertion, mental excitement, colds, tracheal and bronchial catarrh. If œdema is present she must remain in bed, and if signs of failure of compensation arise digitalis or strophanthus should be given. If threatening symptoms arise, abortion should be performed without delay. The introduction of laminaria tents, puncture of the membranes, or dilatation and curettage may be used. Analeptics (wine, coffee, etc.) should be given in the beginning of labor. The patient should lie with the shoulders raised, and not be allowed to bear down. If the cervix dilates slow, dilate it and extract the child and apply a sand-bag to the abdomen. If œdema of the lungs, use venesection and stimulants, like brandy and spirits of camphor. Milk is the best diet in the puerperium, and strophanthus is a good remedy. Ergot should be avoided. Nursing should not be allowed. The patient should remain in bed at least three or four weeks, and resume her ordinary course of living very gradually.

THE DISINFECTION OF THE SKIN WITH FORMALIN (Lenderer).—The reason why asepsis sometimes fails is the difficulty of disinfecting the skin. He has had excellent results in compresses wet with a 1-2 per cent. solution of formalin for 24-48 hours. Stitch abscesses, which occur even when the silk sutures are thoroughly sterilized by boiling, are infections from the skin. Dry dressings are usually sterile, moist ones never. The preservation of the vital energy of the tissues is important, and therefore sharp antiseptics are to be avoided, as well as foreign bodies, blood-clots and necrotic tissue to be removed. The number of sutures or ligatures, for the same reason, should be limited, and hæmorrhage from the smaller vessels arrested by torsion.—*Centralblatt für Gynakologie*, No. 48, 1899.

GEORGE R. SOUTHWICK, M.D.

THE PROPER TIME FOR OPERATING ON ADENOIDS.—This is an able paper, in which the author describes some of the symptoms which follow adenoid hypertrophy, and explains their mechanism, particularly the nasal obstruction which is so often present when it cannot possibly be purely mechanical.

He puts one drachm of the above in a two-drachm bottle, adds the contents of one capsule, shakes the mixtures thoroughly, then filters, and the solution is ready for use.

Mr. F. C. Morgan, of Philadelphia, makes a glycerin extract of the fresh gland; 100 minims of this preparation are said to represent $67\frac{1}{2}$ grains of the fresh gland. Ten drops of this extract (glycerin) added to one drachm of the boric-camphor solution, and well shaken, is ready for use.—C. L. VANSANT, *Phila. Med. Jour.*, February, 25, 1899.

(To overcome this tendency to rapid decomposition, the employment of a glycerin solution has given me very satisfactory results.

Glycerin as an antiseptic is sufficiently active to prevent the putrefaction for some time, without retarding the physiological action of the gland.

The preparation mentioned is prepared as follows:

R. Suprenals desiccated,	ʒj.
Acid boric,	gr. xvj.
Cinnamon water.		
Camphor water (hot).		
Glycerin,	āā ʒss.
Distilled water (hot),	q. s. flʒij.

Macerate for four hours, then filter. Use as a spray.—W. S.)

DYSPHAGIA WITH EXISTING ULCERATION SATISFACTORILY RELIEVED BY THE APPLICATION OF ORTHOFORM.—This drug is a non-toxic anodyne. For intra-tracheal injections, he advises naphthaline treated with an emulsifying agent, lanoline, 3 per cent.—R. LAKE, *Jour. L. R. et O.*, February, 1899.

A CASE OF INITIAL AND POST-INITIAL SCLEROSIS OF THE EYELID.—Gruder, Leon (*Wein. Klin. Wochenschr.*, October 13, 1898).—As to the relative frequency of syphilitic disease of the eye, statistics differ widely; so, too, is the exact proportion of chancre of the eye to other extra genital chancres undetermined. It may be stated that, next to the lips and fingers, the eye is the most common site for the extra genital lesion. As the habits and social conditions of one country differ from those of another, and those of large cities from those of country districts, great variation is to be expected in the statistics on the subject.

The usual frequency of primary chancre of the lids among the Russian peasantry is explained by the custom of licking the inflamed eye, or bathing it with urine. The most common site is on the lower lid; occasionally the upper lid is invaded, and more rarely the conjunctiva. The lesion itself does not differ from that seen elsewhere in the body; it is usually solitary, although a limited number of cases (7) are recorded in which there were two initial lesions.

The contagion is transmitted indirectly by sponges, handkerchiefs and towels, and directly by kissing, licking and the like. The prognosis is generally not grave; small cicatrices will follow resolution, but no gross lesions are to be anticipated. Enlargement of the preauricular glands has no special significance, as this is a complication met with in connection with numerous other ocular affections.

Gruder reports a case of double chancre of the lid in which the manner of transmission was believed to be through the kisses of a syphilitic child.

WILLIAM SPENCER, M.D.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

KOLA IN ASTHMA.—Brown, of Shippensburg, Pa., states that kola, in appreciable doses, as a reconstituent tonic where the nervous system and stomach are at fault, relieves many cases of asthma. It is claimed by some to be specific. Persons addicted to the use of tobacco who are afflicted with asthma are undoubtedly greatly benefited by putting twenty drops of kola tincture into a two-ounce pack of pure tobacco and, after twelve hours, smoking it. The result is often little short of magical.—*Med. Century*, April 1, 1899.

FOR THE QUICK RELIEF OF ASTHMA.—During an attack of asthma, perhaps the greatest relief can be obtained from inhalations of pyridin. In cardiac types, amyl nitrite acts equally well. Sometimes, during an attack, relief is experienced upon spraying rapidly the back and chest of the patient with chloride of methyl.—*Ibid.*

REMEDIES IN MYOPIA.—Aside from remedies which may be required to restate the patient to good general health, there are a number of drugs especially applicable to the conditions accompanying myopia. A few which Bissell, of Rochester, has used with benefit, are :

Jaborandi.—Spasm of the ciliary muscle ; reflex irritation from the genital organs.

Physostigma.—Spasm of the ciliary muscle, asthenopia in high degrees of myopia.

Ruta.—Asthenopia from uncorrected ametropia and improper use of eyes ; choroiditis.

Gelsemium.—Congestion of deep structures of the eye ; choroiditis ; detachment of retina.

Kali iodide.—Especially useful in advanced chorio-retinitis ; syphilitic history.

Prunus spinosa.—Chorio-retinitis, with considerable pain ; fluidity and opacities of vitreous ; an excellent remedy.—*Hom. Eye, Ear and Throat Journal*, March, 1899.

CRATÆGUS IN CARDIAC HYPERTROPHY WITH ACUTE DILATATION.—Halbert reports the case of a young man, aged sixteen, with a heart already hypertrophied as the result of hard manual labor, in whom some gymnastic strain induced an acute dilatation. When first seen he was obliged to lie down, respiration was labored and irregular, and the heart's action was greatly exaggerated and erratic. There was decided precordial bulging ; the apex beat was displaced downward and to the left, and the whole cardiac dullness

was greatly extended ; the impulse was heaving in character, with considerable mitral systolic blowing, and the corresponding diastolic intensification ; there were also signs of pulmonary engorgement, with some chest pain.

After a warm bath, rest in bed, and aconite 3x for a day or two, *cratægus*, five-drop doses of the tincture, was administered five times daily for a long time. The results were striking ; the cardiac irritation gradually lessened, the area of dullness decreased and the rhythm improved, and at the same time all the general symptoms rapidly changed for the better. From his experience in this case and others, Halbert is led to believe that we have never had such a safe and sure remedy as *cratægus* for such conditions. While it is a cardiac tonic, it is not a dangerous one like *digitalis*, and it can be continued indefinitely without untoward results.—*Clinique*, March 15, 1899.

THE THERAPEUTICS OF PULMONARY PHTHISIS.—In the course of a paper presented to the British Homœopathic Society, Arnold, of Manchester, states that the homœopathic drugs which he had found most useful are *sanguinaria*, *jaborandi* and iodide of arsenic. The first named has a definitely curative action in early phthisis, while *jaborandi* never fails to check night sweats.

Wheeler, of Kingston, stated that among homœopathic drugs phosphorus and iodine had proved disappointing, but iodide of arsenic in the early stages, where there is much coughing, with scanty expectoration, is of great value. Later on *stannum* or *hepar sulph.* is to be preferred. *Tuberculin* had not yet been found to clear up a case that resisted other treatment. As intercurrent remedies, *hyoseyamus*, *conium* and *drosera* (especially the last two), although they do not affect the physical signs, often do much for the patient's comfort. For sweating, *ac. phos.* or *silica* ; or *jaborandi*, an old discovery of the orthodox, is a splendid remedy if the sweating is bad enough to resist the first-named. For *hæmoptysis*, *ferr. acet.* and *millef.* had been used with much success.—*Monthly Hom. Rev.*, April 1, 1899.

CHLORIDE OF GOLD IN DISEASES OF THE NERVOUS SYSTEM.—Halbert asserts that of the many remedies which have been experimented with in the degenerative diseases of the nervous system, few have yielded results worthy of much consideration. Such diseases at best have, under any treatment, manifested but slight tendency to recovery. Chloride of gold, however, he believes to be a favorable exception. He has studied it in many complicated diseases, and is now satisfied that it will accomplish more in sclerotic and exudative degenerations than any other remedy heretofore used. As illustrations of this he records cases of multiple sclerosis, exudative localized meningitis and Morvan's disease, in all of which good results were obvious, and in conclusion he states that these are only samples of cases which he expects to report in the future as greatly benefited by this remedy.—*Clinique*, March 15, 1899.

REMEDIES FOR HYPERCHLORHYDRIA.—In the course of an article upon acid dyspepsia, Adams, of Cleveland, mentions the following leading remedies :

Nux vomica.—For the nervous, debilitated, irritable man, who has confined himself too closely to business. Perhaps he has also indulged too freely in spiced foods. He is too easily disturbed by little inconveniences. Feels tired in the morning, or at other times when not under the influence of excitement or stimulants.

Lycopodium.—When there is a great deal of gas in the intestinal tract, with constipation; urine contains uric acid or many urates; an excessive appetite, which may or may not be easily satisfied.

Ignatia.—For the patient, usually a woman, who has met with some affliction. Has a tendency to melancholia, and although she may not say much, impresses all who meet her with the idea that she is a much-abused person.

Kali phos.—For the hysterical erethistic patient; gloomy, foreboding and debilitated. Difficulty in getting to sleep at night, with exciting dreams when successful. Passage of large quantities of urine with low specific gravity.

Bryonia.—Morose and irritable, a heavy, dizzy feeling in the head, with nausea and vomiting upon motion, excessive thirst and extreme constipation.

In addition to these few remedies there are many others which will be perhaps less frequently useful, but which, when indicated and employed in conjunction with other methods of treatment, hygienic, dietetic, chemical and local, will have great power.—*Medical Century*.

EUPHRASIA IN PROSTATIC TROUBLES.—Ames, of Rockland, Ohio, reports a case in which euphrasia 3x was given to a man, aged 79, for lachrymation and sneezing. Later he reported that for a number of years he had been compelled to urinate frequently at night, but that since taking the medicine he had been greatly relieved. While euphrasia is not known to be a prostatic remedy, the writer resolved to experiment with it in a similar case, and the results were favorable. Two years later the first case suffered a return of the trouble, and was again promptly relieved by euphrasia.—*Med. Century*, April 1, 1899.

THE CONSTIPATION OF SILICA.—The constipation of silica is peculiar in that the stool partially escapes from the anus and then slips back, due to rectal inertia. This symptom is also found under stannum, but that has a complicating uterine prolapse.—*Ibid*.

REMEDIES FOR WRITER'S CRAMP.—According to Horner, while medical treatment has no great effect, cases have been reported as cured by gelsemium. Other remedies which may have an influence are arnica, rhus tox., causticum, belladonna and ruta.—*Ibid*.

THE EFFECT OF SILICA UPON NUTRITION.—As stated by Burch, of Chicago, the chief effect of silica is exhibited in its interference with nutrition, hence its usefulness in growing children. The child is imperfectly nourished on account of defective assimilation, not because of improper diet or imperfect digestion. The head is too large for the rest of the body. The fontanels remain open, and the head is covered with perspiration. The limbs are emaciated, but the abdomen is large, round and plump. The face is pale, waxy or earthy. The muscles are weak, the bones imperfectly developed, and the child is late in learning to walk. The fibrous tissues about the joints are inflamed, giving the articulations a knob-like appearance. The extremities are habitually cold, and the feet incline to sweat.—*Ibid*.

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FERRUM PHOSPHORICUM IN SUPRAORBITAL NEURALGIA.—Dr. Parenteau, directing attention to the assertion of Dr. Nimier that this drug is useful in right-sided supraorbital neuralgia, with morning exacerbation, reports three

cases in point which confirm this. The patients are usually women, and notably young girls, or at least young women who are irregular in menstruating, and with special uterine disturbances, with a tendency to hæmorrhages from the uterus. There are nearly always persistent headache and anemia, which, according to the case, is more or less pronounced.—*Revue Homœopathique Belge*, Année 25, No. 8. (The article to which he refers is by Nimier, and, with two others on ferrum phos., was translated into German and appeared in the *Zeitschrift des Berliner Vereines homœopathischer Aerzte*, Bd. xvii., Hft. 2. He mentions it in neuralgia when there is associated violent headache, with throbbing pain, ameliorated by nose-bleed. The headache preceding the menses comes under this heading. The neuralgia is seated in the right supraorbital region, appearing mornings. Dr. Cartier recommends it in congestion of blood to the head.)

I have found it an excellent remedy in congestions of the *lungs*, liver, and especially of the *kidneys*, in old, debilitated, diseased and broken-down subjects, where it may be employed with great satisfaction in the "congestive attacks" of cases of chronic Bright's disease, where, for example, they have been creeping along comfortably when suddenly a cold, a bronchitis, a congestion of the kidneys or the grippe seizes upon them and upsets their balance. Here the remedy may actually act to save life. Aconite will not do it. There seems to be a condition of hyperæmia, rather than active congestion, such as would indicate aconite. Nimier calls attention to its usefulness in children and debilitated persons, and quotes Cowperthwaite to the same effect. Since I have found out its usefulness here, I meet such congestive attacks, as the English say, without much fear, for the time being, at least. I remember one case of uræmic vomiting in an old and weakly woman who, with a chronic cirrhotic kidney, contracted the grippe. Her urine became fairly saturated with reddish urates, until the water seemed like a solution of Venetian red. There was a great deal of albuminuria, continuous vomiting, with eventual empty retching which was distressing to hear. She refused food and gradually grew weaker; her heart became very irregular, weak, and intermittent, and she was practically handed over to the Church. I commenced ferrum phos. 3x on general principles, as I feared the depressing effect of aconite; she had a little temperature, and there was grippe in the family and throughout the neighborhood in full blast. The next day she was a great deal better, ate well, and had passed a fair night; the uræmic retching had decreased. The urine was somewhat better. I continued the remedy. She slowly improved in every way, now and then having a poor day, yet in two weeks she was in fairly comfortable condition, and she slowly and gradually regained enough health to be about again.

THE CLINICAL APPLICATION OF ACONITUM NAPELLUS.—Dr. Krœner, of Potsdam, Germany, in an elaboration of the clinical part of an exhaustive article by the Berlin Association of Homœopathic Physicians on this remedy, appends a number of clinical footnotes:

Psychic Affections.—The most prominent symptom in poisonings by aconite is the restlessness and anxiety, which may increase to mortal anguish. As aconite has no tendency to bring about profound anatomical lesions its action is rather violent but relatively transitory; it will be employed only in symptomatic alteration of mental activity; above all, in febrile diseases of an acute nature. In chronic psychic diseases it will be but seldom indicated.

Nervous System.—The nervous, like the psychic, are only symptomatic, and chiefly point to the drug being used in acute febrile diseases. Also in nervous affections which are due to a shock effect, as fright, it may be employed.

Fever.—The type of aconite fever is the sthenic variety, with an accelerated, full, and at first hard and tense pulse. In the stage of remission the pulse becomes full and soft, or even dicrotic. There are three stages: Chill, fever and sweat. The thirst is principally pronounced during the heat stage. In the chill period the patient asks to be warmly covered, which helps but little. Aconite is mostly indicated in the so-called fever from catching cold, the chief cause of which is dry, cold air or an east wind; febrile and acute catarrhs, croupous pneumonia, endocarditis, pleuritis, acute articular rheumatism, etc., all in the first stage. Aconite is generally useless in intermittent fever, in septic fevers and those dependent upon a primary focus of inflammation, the so-called symptomatic fever. The characteristic features are the restlessness, throwing one's self about, the anxiety, which may increase to mortal anguish. If the disease has become localized, as in pleuritis, it must be changed for another remedy.

Head.—Here two forms of aconite headache are to be differentiated: the purely symptomatic headache and the trigeminal neuralgia. The former, the regular associate of the fever, is situated in the forehead, and is chiefly pressing, dull, with a sense of outward pressure, with confusion and distress in the head. Red face and a feverish pulse complete the picture. The neuralgia is either pressing or sharply stitching and supra- or infra-orbital. The face may be, according to the degree of the poisoning by aconite, either red and feverish or pale and cool. Clinically, aconite has been fully worthy of confidence in neuralgia. In the headache the mental symptoms are to be kept in mind.

Eye and Vision.—In the first stage of the different acute, inflammatory eye diseases, which are dependent upon cold, wind, or even trauma, the tissues affected are injected, the conjunctiva mostly dry, with dull and preservative or sharp and stitching pains. In specific inflammations, as trachoma, scrofulosis and syphilis, it is only to be used as an intercurrent remedy in acute exacerbations. In acute rheumatic paralysis of the oculo-motor nerve it may be employed at the beginning.

Ear.—Chiefly serviceable in acute, painful inflammations of the middle ear, drum-head and external meatus, with redness and swelling, before the formation of an exudate or abscess.

Nose.—A coryza in the first stage, the nasal mucous membrane is red, swollen; the secretions are scanty, with fever and headache. Nose-bleed, with bright-red blood.

Face.—Facial neuralgias; stitching pains, with formication and a feeling as if the face were asleep. In fever the facial expression is anxious, red, hot and dry.

Mouth.—Rheumatic, neuralgic toothache, with redness of the mucous membrane and cheek. Difficult dentition of children, where the inflamed condition of the mouth determines the choice of the remedy. Acute glossitis.

Pharynx and Throat.—Only at the beginning of acute inflammations, pharyngitis, tonsillitis. Redness, swelling, stitching dryness, and the absence of exudate or pus.

Stomach—The associated symptoms of fevers, or possibly from nervous shock—fright.

Abdomen.—Often indicated in the early stages of acute, inflammatory processes in the abdomen, before the appearance of an exudate ; peritonitis, enteritis, with violent, colicky pains ; after cold, hepatitis and perihepatitis, pelveo-peritonitis. The fever is pronounced, the pain severe, but, above all, with restlessness and anxiety.

Rectum and Stool.—In inflammatory hæmorrhoids and hæmorrhages from the bowels. In dysentery, cholera with fever, restlessness and anxiety.

Urinary Apparatus.—In the initial stages of different acute inflammatory processes, or in exacerbations of chronic ones ; cystitis, prostatitis, acute or chronic, with exacerbations, violent pains in the kidneys, with bloody urine, rarely in nephritis ; retention of urine in children and adults, if no mechanical hindrance be present. Fever, pain, restlessness, anxiety, dark or bloody urine, are indications.

Female Sexual Organs.—Suppression of the menses from emotions, taking cold, with the characteristic nervous symptoms. Metrorrhagia, with bright red blood. In the beginning of acute inflammations of the male and female sexual organs.

Respiratory Organs.—Acute affections of the organs of respiration after catching cold ; laryngitis, tracheitis, acute bronchitis, croupous pneumonia in the first stage, dry pleurisy. The fever and the mental symptoms should correspond. With the formation of an exudate another remedy is indicated. The cough of aconite is dry, rough, painful, the expectoration scanty, sometimes blood-streaked or rust-colored. Also in hæmoptoe, acute congestion of non-inflammatory origin, where it is a precious remedy—*veratr. vir.* and *ferr. phos.*

Heart and Circulation.—In acute inflammations ; carditis, endocarditis and pericarditis, in the first stage invaluable. The characteristic feeling of anxiety is present. In angina pectoris, with a collapsic state, stitches in the cardiac region, formication and numbness of the left arm.

Neck, Back and Extremities.—In acute febrile, rheumatic affections of the neck and back-muscles. It has been used with good results in neuralgias of the upper extremities, with numbness, sometimes occurring after suppression of sweat. Also in acute sciatica, acute muscular rheumatism in the beginning, and in true gouty attacks. The rheumatic pains often are ameliorated by fresh air.—*Zeitschrift des Berliner Vereines Homœopathischer Ärzte*, Bd. xvii., Hft. i., 1898.

TREATMENT OF PERNICIOUS FORMS OF MALARIA—OF THE DELIRIOUS FORM.—Dr. Léon Simon, together with the quinine salts in the apyretici intervals, advises the following concomitant drugs :

Belladonna.—Furious delirium, hallucinations, terror and a desire to hide or to escape, to strike, to injure. *Hyoscyamus.*—Extravagant delirium, dances, sings, obscene gestures, maliciousness or somnolence with carphologia. *Stramonium.*—Alternating delirium and sadness. *Nux moschata.*—The double tertian type, but scanty sweat and as red as blood. Somnolence associated with delirium ; the chill comes on in the evening. *Cannabis indica.*—Delirium, exaggeration of all the perceptions and ideas, with a tendency to catalepsy. This drug is of service in those addicted to drunkenness, a vice which is certainly not rare in negroes. *Aconitum.*—Fixed ideas and fear of death. *Pulsatilla.*—Sadness and a tendency to weep. *Ignatia.*—Involuntary sighs, desire for solitude, mobility of emotions, versatility.

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HAHNEMANN AND THE ALTERNATION OF MEDICINES.

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HAHNEMANN has not been dead sixty years and yet he is by some of his followers apparently regarded as a myth and his writings as oracles.

The founder of a new faith—though only in medicine—he and his writings are going through the phases familiar to us in the history of the course and progress of other reformers and their doctrines. Homœopathy has its sacred and inspired works; its dogmas, liable to various interpretations; its sectaries, each of whom maintains that he alone is orthodox and all others are schismatics or heretics; even its renegades, who revile what they formerly extolled. And lastly, there are the partisans of particular dogmas who, finding the letter of the book against them, fall foul of the imaginary transcriber or of the translator, and ascribe to the *lâches* of the latter the apparent antagonism of the *littera scripta* to their own interpretations. Thus we have seen how the partisans of the formula *similia similibus curantur* accounted for the fact that it occurs as *similia similibus curentur* in all the six places where only it appears in the Master's writings (viz., the five editions of the *Organon*, and in Hahnemann's letter to the French Minister of Instruction, reproduced in the *British Journal of Homœopathy*, vol. 38, p.

65), by boldly asserting that it was altered by an unscrupulous or careless transcriber, and that the true phrase of Hahnemann was not "let likes be treated by likes," but "likes are cured by likes," forgetting that the Latin word "curare" means to "take care of" or "treat" and not to "cure," and that if Hahnemann meant to say "likes are cured by likes" he would have written "*similia similibus sanantur*." The complete formula might run "*similia similibus curentur quia similia similibus sanantur*"—"let likes be treated by likes because likes are cured by likes." The late Dr. Adolf Lippe—who ought to have known better—actually attributed the alleged substitution of "curentur" for "curantur" to our Dr. Hughes!

Again, we have seen how the so-called "high-potency" sectaries, probably influenced by some such statement of the Master as we find in section 279 of the *Organon*: "The dose of the homœopathically selected remedy can never be prepared so small that it shall not be stronger than the natural disease, and shall not be able to overpower, extinguish and cure it," have devoted their concentrated energies to the mere dilution of the drug; in their one-sided zeal neglecting the precise directions of Hahnemann as to how his attenuations should be prepared. In place of spirits of wine enjoined by Hahnemann, they use ordinary service water with all its impurities, and, in place of the succussions to each stage of the dilution in a separate phial for every step, insisted on by Hahnemann and considered by him as essential to the development of the remedial powers of the medicine (*v. Chr. Kr.*, i. p. 180), and of which he says: "It deserves incontestably to be reckoned amongst the *greatest* discoveries of the age" (*M. M. P.*, ii., p. 44), the makers of the "high-potencies" mostly allow their impure aqueous medium to run through one bottle, without any attempt to employ what Hahnemann considered the most essential manœuvre in his process. Whilst Hahnemann protests, in his letter to Dr. Schreter, against diluting beyond the 30th centesimal attenuation, the "high-potency" sectaries carry their dilutions to an inconceivable extent. They profess to furnish dilutions up—or rather down—to the 10,000th, 100,000th, 1,000,000th and even 500,000,000th degree. Surely those who believe that such "potencies" are what their makers call them, must say with the old theologian "*credo quia impossibile*."

There is yet another, though probably a small, sect, led by the notorious Jenichen, who make their potencies by succussion only, without troubling themselves about dilution. They use a bigger bottle and reckon every ten or more succussions a "potency." Probably the following passage in the *Organon* (note to section 270) suggested this mode of procedure: "I dissolved," says Hahnemann, "a grain of soda in half an ounce of water mixed with alcohol in a phial, which was thereby filled two-thirds full, and shook this dilution continuously for half an hour, and this fluid was in potency and energy equal to the 30th development of power."

And now we have Dr. Leach, who has been converted, as he tells us, to the belief that Hahnemann never could have practiced or advised giving medicines in alternation, because, as Dr. Frank Kraft says: "The logic of his whole system of medicine would confute him at every point" (whatever that may mean), accusing us miserable translators of having mistranslated the passages in Hahnemann's writings which apparently recommend the alternation of remedies. I am the chief offender in this matter, though I have as copartners in my guilt my worthy friend Dr. Conrad Wesselhoeft and the learned Mr. Tafel. Dr. Leach kindly invites me to repent and acknowledge the error of my ways. And so I shall when I am convinced that I have committed the dreadful crime of mistranslating my author.

Dr. Leach asserts that all the translators into English of Hahnemann's works have failed to give the correct sense of the words we have rendered "alternate" and its derivatives (*abwechseln* and once *alterniren* are the words Hahnemann uses). He acknowledges that this is the *literal* translation of Hahnemann's word, but asserts it is not the *equivalent* of it. He gives us no authority for this statement, so it is only his unsupported *ipse dixit*; in fact, he regards it as a discovery of his own, of which he is extremely proud, and which should entitle him to the gratitude of those who have hitherto been uneasy in their minds on the subject. He asserts that the true *equivalent* of the word we have translated "alternation" is "entirely different" from our *literal* rendering of it—"in fact, its *antonym*." I have searched through all the English dictionaries within my reach and cannot find this word; it is not even in the great American dictionary of Webster, so I suppose it is a word coined by

Dr. Leach himself. I presume, from the context, Dr. Leach intends to imply by it that the *literal* is the "opposite" of the *equivalent* rendering of the word, but if so, why does he not say so in terms understandable on both sides of the Atlantic? Another strangely unfamiliar word Dr. Leach is fond of using is "rendition" in place of "translation." In our benighted country we still think of it only in the sense of "surrendering," as Johnson taught us; thus we might speak of "the rendition of Santiago to the American commander." But, in fact, Dr. Leach's English is very hard to understand. Can any mortal make out what he means by this sentence? and he has many more equally incomprehensible to the British intellect: "If, therefore, Drs. Dudgeon and Wesselhoeft have mistranslated Hahnemann's *Organon*, their respective renditions of this masterpiece, when duly analyzed, will refute any asseverations to the contrary, while, if these gentlemen have given us the English *equivalent* of the German text, their several editions of these laws of Homœopathy stand as even more glorious monuments to their efforts; and of such analysis I now most respectfully ask their consideration, as well as the attention of all contemporary students of Hahnemann's several publications wherein he makes use of the verb 'abwechseln,' and its modifications, as they have been interpreted for us." I have read and re-read this puzzling sentence, but my intellect is unable to divine its meaning. It is, and I fear must remain, as profound a mystery to me as the title of Dr. Leach's paper "*summa summarum alternationis*," unless Dr. Leach will come to the rescue of my dulness and translate it into intelligible cisatlantic English.

But to return to the subject of our alleged mistranslation of Hahnemann's words. A good many comments on Hahnemann's remarks about the alternation of remedies have been made by German authors, who may be credited with having some idea of the sense in which Hahnemann used the expression; and none of them seems to have the slightest doubt that he meant the administration in alternation of two or more remedies. I may mention the names of Griesselich, Constantine Hering, Gross, Rummel, Hartmann, Aegidi, Hirsch and others, all of whom speak favorably of the alternation of medicines in certain cases, and all of whom comment on the undeniable fact that Hahnemann occasionally recommended and employed this practice.

I may here mention the places where Hahnemann does this. The first three editions of the *Organon* have the following paragraph:

“It is only in some cases of old chronic diseases, not subject to any important change, which present certain fixed fundamental symptoms, that sometimes almost equally homœopathically suitable remedies may be employed *alternately* with advantage.” (First edition, section 145.) In the same three editions of the *Organon* we find the following paragraph: “When a thoroughly suitable specific (homœopathic) remedy cannot at once be found, on account of the deficiency of medicines whose pure effects have been ascertained, there will usually be one or two next best medicines for the characteristic original symptoms of the disease, one or other of which—according to the morbid state in each case—may be useful as an intercurrent remedy, so that its administration in *alternation* with the chief medicine promotes the recovery much more palpably than giving *only* the chief medicine, most, though still imperfectly, suited amongst all those we possess, two or three times in succession.” (First edition, section 211.)

In an article on *Cholera*, in the *Archiv f. d. Hom. Heilk.*, vol. xi., pt. 1, p. 126 (trans. in *Lesser Writings*, p. 847), Hahnemann says that in a typhoid state, with delirium sometimes following cholera, *bryonia* 30 *alternately* with and *rhus tox.* 30 proves very serviceable.

In a communication to the first volume of the *Bibliothèque Homœopathique*, Hahnemann recommends for the second stage of cholera *cuprum alternately* with *veratrum*, and he also advises these two remedies in *alternation* from week to week as a preventive of the disease.

In his *Examination of the Sources of the Ordinary Materia Medica* prefixed to the third volume of the second edition of the *R. A. M. L.*, 1825, p. 57, note, (*v.* my translation of the *M. M. P.*, vol. ii., p. 28. By the way, I may state here that I alone am responsible for this translation, and that Dr. Hughes had nothing to do with it except looking over the proof sheets, supplying some notes on Hahnemann's quotations and suggesting some emendations in the phraseology of the text, so that Dr. Leach's expression, “translated by Hughes and Dudgeon” is incorrect. He is equally wrong in coupling Dr. Marcy's name

with mine in the translation of the *Lesser Writings*—of which he does not seem to have the English, but only the pirated American edition—and Dr. Hughes's name with Tafel's in the translation of the *Chronic Diseases*.) Hahnemann in this essay, says that he found the remedy for purpura miliaris was *aconite* occasionally *alternated* with *coffea cruda*, and that he discovered that *spongia tosta* and *hepar sulphuris*, given *alternately*, cure croup.

In the second and third editions of the *Organon* (note to par. 180) Hahnemann says: "Only in complicated disease, *e.g.*, where, in addition to the venereal chancre disease, the condylomatous, or mayhap the psoric, disease dwells in the body, it is impossible to complete the cure with a single medicine. Here each appropriate homœopathic (specific) remedy for one and the other disease must be employed *alternately*; for the first mentioned complication the best *mercurial* preparation in *alternation* with the best preparation of *sulphur*, until both are cured."

In the *Chronische Krankheiten*, vol. i., second edition, 1835, Hahnemann recommends for the condylomatous gonorrhœa *thuja* 30 *alternately* with *nitric acid* 6 (not 30, as Dr. Leach, or is it Tafel? has it).

In the first volume of the *R. A. M. L.*, third edition, 1830 (see my translation of the *M. M. P.*, vol. i., p. 200), Hahnemann says that all cases of the red miliary (purpura miliaris) might be cured by the *alternate* administration of *aconite* 30 and *coffea cruda* 3.

In the first volume of the *Chr. Kr.*, second edition, 1835, at p. 165, note, Hahnemann says that intermittent fever must sometimes be treated with *ipéc.* *alternated* with *nux vomica*, sometimes with *cina* alone or *alternated* with *capsicum*; *arnica* alone or *alternated* with *ipéc.*

For an exquisite example of alternation of medicines, without any reference to possible change of symptoms caused by previous remedies, I may refer to Hahnemann's letter to Wislicenus, translated by me and published in the *Homœopathic World* for March of this year.

The above examples from Hahnemann's works have hitherto sufficed to convince Hahnemann's commentators in Germany and other countries that Hahnemann regarded the alternate administration of two or more remedies in acute and chronic

diseases as occasionally allowable, and even advisable. Dr. Leach is evidently not a believer in the literal inspiration of the sacred books of homœopathy, but, like some other sectaries in other spheres of faith, interprets the words of the Master in a non-natural sense of his own, and labors hard to show that when Hahnemann advises that medicines should sometimes be given in alternation, he did not mean alternation at all, but something “entirely different”—“in fact its antinym.” In another place he says we (the translators) “have given the *literal* transcription (meaning probably *translation*) of such words (*abwechseln*, and so forth) which are indisputably *antinym*s to the same.” Well, as I have not the remotest idea of what an “antinym” is, I cannot dispute about it, and must leave Dr. Leach to the undisturbed enjoyment of his discovery that, in translating literally, I have perpetrated an “antinym,” which for aught I know may be a *monstrum horrendum, informe, ingens, nulla virtute redemptum a vitiis*. If that is so, I can only say I hope I may be forgiven as I did not do it on purpose, and will try not to do it again, when I know what it means.

Dr. Leach asserts that Hahnemann “never found such practice (viz., alternating medicines) necessary,” in spite of all the instances of alternation he quotes and I have given, and he thinks he has found “an unqualified admonition to the contrary” (meaning, I suppose, a distinct condemnation of the practice of alternating medicines) in section 272 of the *Organon*, which he misquotes by tacking on to the paragraph a foot note which does not form part of the original paragraph. The paragraph is: “In no case is it requisite to administer more than *one single, simple* medicinal substance at one time.” This paragraph is the same in all the five editions of the *Organon*. In the fifth and last edition only do we find the note, which runs as follows (I prefer my own translation as being the most *literal*—at the risk of its being pronounced an “antinym” by my censorious critic): “Some homœopathists have made the experiment, in cases where they deemed one remedy suitable for one portion of the symptoms of a case of disease, and a second for another portion, of administering both remedies at the same or almost the same time; but I earnestly deprecate such a hazardous experiment, which can never be necessary, though it may sometimes seem to be of use.” This paragraph and the

note have nothing to do with the practice of alternation of medicines.

The history of the introduction of this note into the last edition of the *Organon* may not be generally known, so the readers of the *HAHNEMANNIAN MONTHLY* may like to hear it. I am enabled to give the true account of the matter, as I have it before me in a letter I received from Dr. Aegidi in June, 1865. In 1832 Dr. Aegidi meeting with some cases in his practice where there was a difficulty in deciding which of two medicines was most indicated, one corresponding more to one portion of the symptoms, another to another portion, resolved to try what a combination of the two medicines, of course in minimal dose, would do. He goes on to say: "I tested the matter in conjunction with my friend Dr. von Bönninghausen, and, after we had obtained a number of results, we communicated them to Hahnemann, who, having convinced himself by his own trials of the reality of the effects, resolved to devote a special paragraph on the subject in the forthcoming fifth edition of his *Organon*. But the protest against this, made at the meeting of the Central Society of Homœopathic Physicians in 1833, as also mine and Bönninghausen's objection on account of the misuse that might be made of the double remedies, induced Hahnemann to say nothing about it. Indeed, the great abuse of double remedies that occurred after my paper in *Stapf's Archiv* in 1834 compelled Hahnemann and myself to protest against them publicly." This, then, was the sole cause of the appearance of the note to section 272 of the fifth edition. It is, in fact, a mild protest against Aegidi's plan of giving homœopathic medicines in combination and has no bearing on the alternation of medicines, which Hahnemann never explicitly condemned, and he would hardly have done so, as he had occasionally recommended and practiced it himself.

It is well known that Dr. Arthur Lutze, of Cæthen, published in 1865 an edition of Hahnemann's *Organon* with the suppressed paragraph, which any one may read in the 23d volume of the *British Journal of Homœopathy*. In the same work, also reproduced in the *B. J. of H.*, Lutze published two letters of Hahnemann to Aegidi, expressing his warm approval of the administration of double remedies and notifying his intention of publishing a paragraph in their favor in the forthcoming edi-

tion of his *Organon*. Is it likely that Hahnemann, who was prepared to swallow the camel of Aegidi's double remedies, would strain at the gnat of alternation of medicines?

Theoretically it would doubtless be more in accordance with the strict letter of the homœopathic doctrine and practice to ascertain what precise alteration, if any, in the symptoms of a case of disease was effected by one medicine or one dose of a medicine before venturing to give another medicine or another dose, but this is a counsel of perfection that it is impossible in the storm and stress of practice to act up to. If we had a patient constantly under our eye we might presumably be able to do it. But this can never be the case in the ordinary routine of a physician's practice. He does not see his patient constantly. Hours, days, weeks, or even months may elapse between each visit, and he has to arrange for the treatment during the time that his patients are out of his sight. Moreover, diseases are not always simple; often they are very complex; and there are many, as Hahnemann has observed, and as every practitioner knows, where one medicine seems more suited to one set of the symptoms, another to another set. The experienced physician may be credited with the faculty, common to many persons in other walks of life besides medicine, of being able to form "an intelligent anticipation" of what is likely to happen in a given case of acute or chronic disease, therefore it would be perfectly allowable for him to prescribe two or even more medicines in alternation to meet the known complexity or anticipated changes of the disease without forfeiting his claim to be considered a faithful follower of Hahnemann, who has shown by precept and example that such a practice is admissible, and indeed occasionally necessary. As it is only by falsely, as I have shown, asserting that our translations of certain passages in Hahnemann's works are erroneous, that Dr. Leach can get up the semblance of a proof that occasionally giving medicines in alternation is opposed to Hahnemann's precepts and example, now that I have shown that Dr. Leach has hopelessly failed in his attempt to convict Hahnemann's translators of mistranslation, I may leave Dr. Leach and his accusations to the judgment of all intelligent and unprejudiced practitioners of homœopathy.

It would, in my opinion, tend greatly to the advantage of

homœopathy as a successful mode of practice and help to dispel the prevalent prejudices of the general profession against it, if its partisans would cease to regard its author as the inspired Messiah of a new faith, and his *Organon* as an impregnable evangel of a new *religio medici*. Hahnemann was no infallible prophet, but was, in the scriptural sense, ὁμοιοπαθὴς ἑμῖν—"of like passions with us," and his teachings are not dogmas to be received with unquestioning faith, but opinions which require to be subjected to a searching criticism like those of any other reformer. In our study of his doctrines we may form various opinions as to the value of his practical directions and theoretical views; but we may agree to differ on these non-essential points while we remain in perfect accord as regards the great therapeutic rule he first showed to be the true and only guide to practice, which he thus expressed in the last edition of the *Organon*: "To cure mildly, rapidly, certainly and permanently, choose, in every case of disease, a medicine which can itself produce an affection similar to that sought to be cured," and for which he adopted the old formula, *similia similibus curentur*—let likes be treated by likes.

AMYOTROPHIC LATERAL SCLEROSIS.

BY JOHN J. TULLER, M.D., PHILADELPHIA.

ALTHOUGH thirty-four years have elapsed since Prof. Charcot, of the Faculty of Medicine of Paris, and until his death the head of the Hospital Salpetriere, first noticed that a certain number of patients attacked with the symptoms of progressive muscular atrophy developed signs of the involvement of the lateral columns of the spinal cord that could be positively demonstrated, the majority of general practitioners open their eyes in wonder when the name amyotrophic lateral sclerosis is mentioned. So slow is the knowledge of diseases of the spinal cord in entering the general profession that it almost seems as if they were enveloped in a mysterious haze from which they could not be extricated; and yet, when the anatomy and physiology of the spinal cord are thoroughly understood, it is really less difficult to demonstrate the patho-

logical lesions of this organ upon the surface of the body than almost any other vital organ of the entire human organism.

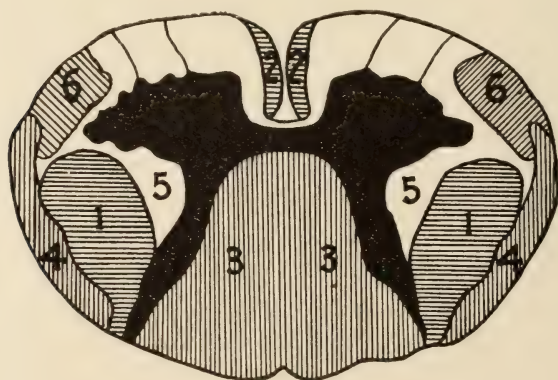
In 1874 Prof. Charcot had progressed so far in his investigation of this disease that he was able to distinguish it absolutely from the other forms of atrophy arising from degeneration of different sections of the spinal cord, and he gave it the name of amyotrophic lateral sclerosis, an atrophy arising from sclerotic degeneration of the lateral columns of the spinal cord. Pierre Marie says this disease can be summed up in three words: "Maladie de Charcot." All honor to the master who first described it. But this is not scientific; we must cling to the scientific name which the master himself gave it. Spasticity is the predominating feature of this disease. In fact, it is the first symptom noted by the patient. At the very onset, the spasticity may be so slight that in all ordinary movements its presence will not be noted unless the victim is called upon to perform some act requiring extreme agility, when he finds that the muscles will not respond as quickly as formerly; that there is a slight stiffness, associated with a peculiar sensation of cramp. At this period the general spasmodic condition of the muscles can again be demonstrated by the marked exaggeration of all the reflexes. Striking the plantar surface of the foot will produce a contraction of the toes; striking the tendo Achillis will cause an extension of the foot; striking the patella tendon will cause an extension of the leg. Strike the palmar tendon at the wrist and flexion of the fingers and hand will be the result; the triceps tendon at the elbow, and extension of the forearm results; the masseter muscle of the face, contraction takes place. The acts of pronation and supination become difficult, and at times painful. Spasticity is the essential feature. The reason of this becomes easily understood when once we have the picture of the pathological lesion well fixed in our minds. Later on, as the disease process continues in the lateral columns and the anterior horns, a mild contraction takes place, which is easily found by the close observer.

The second stage of the disease is announced by the beginning atrophy. This atrophic condition attacks groups of muscles, or single muscles themselves, or even sections of muscles, marking the advance of the disease in the anterior horns. In the spinal form it usually attacks the muscles of the thumbs and

little fingers (thenar and hypothenar) first; then the interosseous muscles of the hand, thrusting the phalanges into prominence, giving the hand much the appearance of a claw. From the hand the atrophy gradually creeps up the arm, and finally becomes general. At the very onset of the atrophy a peculiar character of fibrillary twitching develops in the skin over the region of the muscle involved. This is the announcement of the attack on the cells of the anterior horns, which is very marked, and is most important because it often marks the muscle next to be attacked.

In the bulbar form, or that form in which the medulla is the primary seat of the pathological change, the muscles of the lips, the tongue and the throat are progressively attacked.

FIG. 1.



The atrophy associated with the stiffness of the muscles produces a slightly cramped appearance of the lower face that makes one resemble, as M. Marie says, "a child about to cry." Here, again, the fibrillary twitching is very apparent. Occasionally may be seen this peculiar twitching of one lateral half of the tongue, while the other half rests quiet, proving the beginning degeneration of the hypoglossal nucleus on the corresponding side in the medulla oblongata. As the spinal centre of the motor root of the trigeminal nerve becomes involved, spasticity, fibrillary twitching and atrophy progressively occur in the lips, the muscles of the lower face and the masseter muscles. The lips become separated, and apparently roll open; furrows and ridges appear about the lower jaw, marking the

sections of muscular atrophy, and the lower jaw drops, forcing the mouth open from the paralysis of the masseter muscles.

FIG. 2.

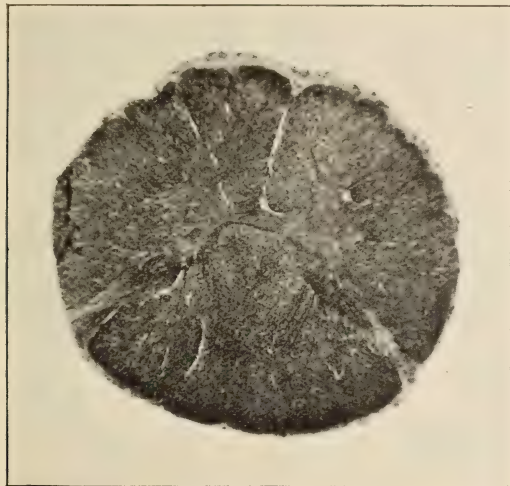
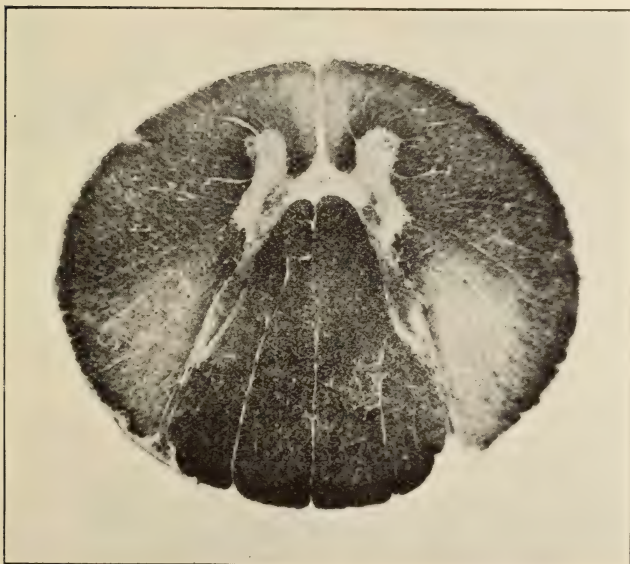


FIG. 3.



The speech, too, becomes difficult, thick, and the words indistinguishable, from the loss of the use of the tongue. It

would take many pages to describe in detail the different conditions found in amyotrophic lateral sclerosis; but the object of this article is not to go into detail, rather to give the grosser symptoms that will aid in the separation of this disease from the other forms of spinal atrophy, and to expose the existence of the pathological cause in the spinal cord. One thing, however, must not be forgotten, which is more prominent in this form of spinal disease than in any other, that the paralysis is out of all proportion to the amount of muscular atrophy.

As the degeneration progresses in the region of the medulla, the spinal centre of the pneumogastric nerve is attacked, and the respiratory organs are involved; the stomach becomes irritable, palpitation becomes frequent, and finally syncope and death.

In no instance is the sensory system disturbed. This disease belongs entirely to the motor function. Late, in some cases, there seems to appear more or less emotional disturbance, but this is probably due to the nervous exhaustion which naturally follows the active degeneration going on in the nervous system. The patients in such cases become more or less childish, easily moved to laughter or tears. Most authors agree that the mind is not involved.

Before entering upon the actual description of the pathological condition it may be as well to review the normal anatomical structure of the cord, that the reader may immediately associate the diseased areas with the normal, and this is best done by a diagram taken from Van Gehuchten. (See page 348.)

Nos. 1, 2 and 5 represent the motor areas of the white matter of the spinal cord. Nos. 3, 4 and 6 represent the sensory areas. The latter we have little, if anything, to do with in this description.

No. 1 represents the cross pyramidal tracts, the areas through which pass the fibres from the cerebrum above which cross in the medulla. No. 2 represents the direct motor areas through which the fibres pass direct from the brain to their point of exit from the spinal cord before decussating. No. 5 represents the area known as the fundamental tissue of the lateral column. It is through this area that the fibres pass which connect the different cells of the gray matter of the spinal cord, the gray matter being represented in the cut by the black section.

FIG. 4.

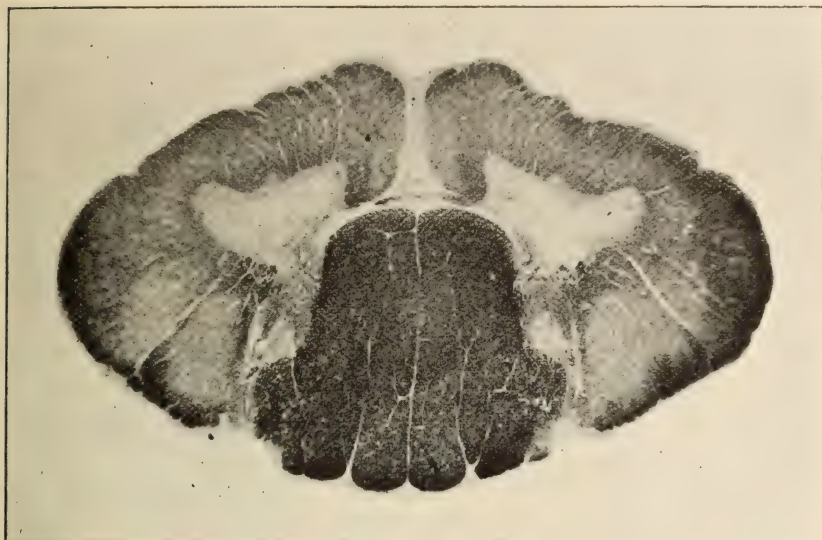
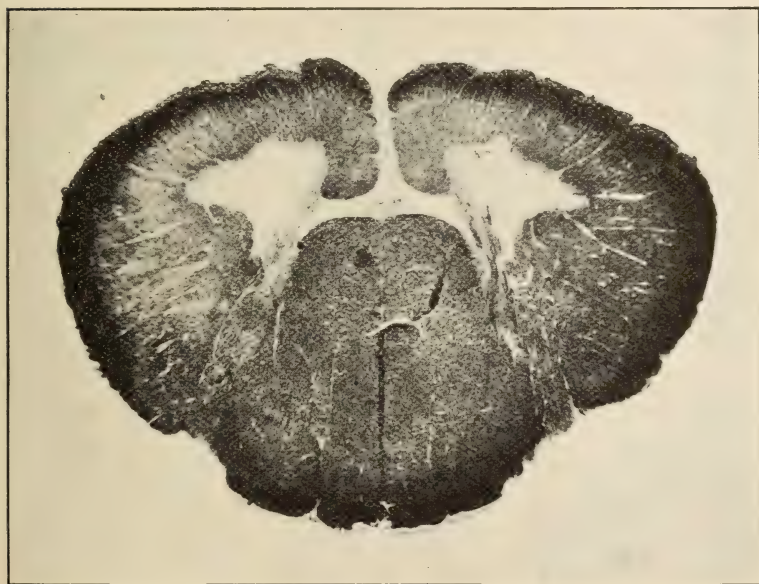


FIG. 5.



The preparations used in this article for demonstrating the pathological changes in the different sections of the cord are taken from the writer's own collection, and were stained with

the Pal's modification of the Weigert hæmatoxylin stain. This stain colors only the normal structures, so that in the preparations those sections which have not taken the stain are the diseased portions. If we place under the microscope a section colored with this stain we find the portions of the cord representing the white substance to be made up of a mass of minute cells, circular in form. These are transverse sections through the fibres, passing up and down through the white substance of the cord. If, now, we raise the power of the objective sufficiently to individualize one of these cells, it will be found to consist of three distinct structures. Directly in the centre of the cell will be seen a transparent spot. This is the axis cylinder. Immediately surrounding the axis cylinder is what appears under the microscope to be a comparatively broad, black band, the myelin or white substance, and surrounding this, the enveloping membrane, normally a very thin sheath. The axis cylinder is not affected by the stain, and the enveloping membrane but slightly so, rendering it a pale, yellowish-white color. The myelin substance takes the stain freely, and is therefore a very deep bluish-black. If a diseased portion of the white substance of the section of the spinal cord be now placed under this high objective, the cells that have not been completely destroyed will be found much enlarged, the outline being almost twice the size of the normal cell, the axis cylinder and the myelin substance to have disappeared or to be in the process of destruction, the enveloping membrane decidedly thickened, and a marked increase in the interstitial connective tissue. This is the character of degeneration found in the crossed pyramidal tracts, in the direct cerebral tracts, and in the fundamental lateral columns, Nos. 1, 2 and 5 in the first cut. There occurs, late in the disease, an apparent degeneration, very slight, however, in the posterior columns; but this degeneration differs under the microscope from that found in the lateral and anterior columns, inasmuch as the cells seem not to increase in size, as from an inflammatory process, but on the contrary to rather diminish from even the normal, as if they had undergone atrophy rather than an inflammatory change. This would, in fact, seem quite natural, as it never appears until quite late in the disease, and then to only a slight degree, after the functions of the posterior

column of the spinal cord (No. 3 of the first cut) have ceased, co-ordination of muscular movement having ceased on account of the extensive atrophy and paralysis.

The other portions of the sensory section of the white substance of the cord remain quite normal, as will be seen by their retaining the stain in the sections used for demonstration.

The gray substance of the cord, represented by the black figure in the diagram, bearing somewhat the form of a letter H, can be divided into an anterior and posterior portion, and a commissure which joins these two lateral halves. The anterior portion is motor, the posterior sensory. It is with the anterior section, or horn, that we have to do. In this section are located the cells, which furnish the nourishment and the continuance of motor impulse to the muscular structure of the body, and they are joined together by the fibres that pass through the fundamental lateral columns. In the process of disease they become atrophied. Their nerve prolongations begin to disappear, and finally a complete destruction of these elements takes place. In the meantime the inflammatory process has produced a new structure of interstitial connective tissue.

Thus it will be seen how the spasticity occurs from the involvement of the fundamental lateral columns, how the paralysis takes place from the disease of the motor areas, the crossed pyramidal and the direct tracts, and how the atrophy follows from the destruction of the anterior horns.

As in the cord, so in the medulla. The disease attacks both the white and gray substances. Here the pyramidal tracts bear the brunt of the degeneration, and the changes resemble much those that follow hæmorrhage into the internal capsule; but in the latter the degeneration is more complete, and results in a permanent contraction of the part affected, while the gray matter is not involved, and atrophy is scarcely ever seen except from the natural reduction in the volume of the muscles from lack of use. Science, to-day, has progressed sufficiently in its investigations to be able to individualize the different centres of the medulla, and to demonstrate the different nuclei attacked by the degenerative process. The first center usually to be attacked is the nucleus of the hypoglossal nerve, causing paralysis and atrophy of the tongue. Quickly upon this fol-

lows the motor nucleus of the trigeminal nerve, then the pneumogastric and facial centers.

When the disease makes its *début* in the medulla, death frequently intervenes before the degenerative process has an opportunity to develop, from the attack upon the pneumogastric center. Death may follow so rapidly in this form that the patient lives but a few months, and the areas of degeneration in these cases are extremely limited. In the spinal varieties the disease is of longer duration and the degenerated areas much more extended.

FLATFOOT.

BY GUSTAVE A. VAN LENNEP, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the County of Phila., March 9, 1899.)

IN the nomenclature of this affection there seems to be considerable confusion, some authors drawing a distinction between talipes valgus and talipes planus, and others describing the affection under the general name of talipes valgus. Flatfoot being a condition in which the normal arching of the foot is lost, the sole being flattened on the inner side, with at the same time abduction of the foot, it seems perfectly just that the term talipes valgus should be applied to it. In some cases either the flattening of the arch or the abduction may be the more marked deformity, yet according to the mechanism of production of flatfoot there cannot be any flattening of the arch without more or less abduction of the foot. There are two classes of talipes valgus—the congenital and the acquired. The former is quite rare. The feet of new-born children are flat, that is the arch is not fully developed until the child begins to walk and the muscles of the foot and leg are brought into action—but even with this tendency to flattening of the arch there is no abduction present, and in fact, if anything, a leaning toward the varus position. In some children, however, the arch fails to form, the instep remaining, as it were, in its infantile form. To distinguish this variety from congenital valgus, the terms congenital splay-foot, or flatfoot, or pes planus

sans valgus, or infantile flatfoot, have been applied. It is not, strictly speaking, a congenital defect, as there is no arrest of foetal development, only a failure to acquire a proper instep at the natural time, that is when the child begins to walk. This condition gives little or no inconvenience, only a peculiar gait, with the feet turned out, but it is best to correct the deformity whenever present, as it predisposes to the production of the graver form of true acquired static flatfoot, as the patient grows older; or simply for cosmetic reasons. The acquired form of flatfoot is very common—more so than is generally supposed. Of this there are several varieties, classified mainly according to their causative factors, as, for instance, the static, the traumatic, the paralytic, the spastic or spasmodic, the rickety, the rheumatic, etc. They all have certain main typical features, differing from one another only in minor peculiarities. The ætiology, pathology and treatment is practically the same.

For convenience sake, acquired flatfoot is divided into several degrees, according to its severity. Briefly, they are:

First degree, incipient flatfoot.

Second degree, pronounced flatfoot.

Third degree, rigid flatfoot.

Fourth degree, extreme or osseous flatfoot.

In the first degree the displacement of the bones is very slight, and the ligaments only stretched a little beyond the normal. The arch can be readily restored by the patient sitting down, or rising on tiptoe, or inverting the foot when standing.

The condition is more marked in the second degree. The patient cannot restore the arch by any of these means, but the surgeon is able to do so by using only a slight amount of force. In the third degree the deformity cannot be reduced, either by the patient or by the surgeon, without his using an excessive amount of force, on account of the muscular spasm and ligamentous adhesions. And, lastly, in the fourth degree, osseous changes occur which render the deformity irreducible, even with the aid of an anæsthetic.

The typical flatfoot is the static, that produced by long standing or weight-bearing, the flatfoot of "waiters," "policemen," "barbers," and others whose daily occupation necessitates their standing for long periods at a time. Let an individual with a poorly-developed arch or an arch with lax, weak ligaments be

compelled daily to stand for hours at a time, and you will invariably have the production of a typical flatfoot. The position such persons assume in standing also has much to do with the breaking down of the arch. This has been called by Annandale the "attitude of rest," *i.e.*, standing with the feet wide apart, toes turned out, or, first on one foot and then on the other, with the feet or foot in each case abducted. This is the weakest position for the foot—adduction being the strongest—and when the foot is in the abducted position, the weight of the body, instead of being transmitted for the most part to the heel, is directed downwards and inwards towards the forepart of the *os calcis*, the astragalus being borne downwards and inwards likewise, and carrying the scaphoid with it, so that the weight of the body is almost entirely thrown on the ligaments of the innermost side of the arch (calcaneo-scaphoid and calcaneo-astragaloid). These supports naturally give way under the continuous strain, especially if, for any reason, they are lacking in tone, with the result that the astragalus, with the scaphoid, is rotated farther and farther inwards and downwards, and finally, if not checked, reaches the ground. However, not everyone who stands acquires flatfoot, so we must look for a predisposing cause. This is either a poorly-developed arch, or an individual who, on account of sickness or debility, is lacking in general muscular and ligamentous tone. We have flatfoot developing in persons who, previously strong, are convalescing from acute illness. Rapid growth is possibly the most common predisposing factor. The large majority of flat feet are developed between the ages of fifteen and twenty years. At this time the tissues grow so rapidly that they have no strength left to overcome faulty attitudes in standing or walking, or excessive weight-carrying. Deprivation of muscular action, weakness of certain groups of muscles, inequality in the length of a lower limb, rickets, rheumatic fever, are all predisposing causes. Traumatism also plays an important part; thus a blow on the instep may so strain the ligaments of the foot that they readily yield and flatfoot is ultimately developed. The trauma in this case is a predisposing cause, or if the injury is severe enough to cause an actual laceration of ligaments, or muscles, which play an important part in maintaining the arch of the foot, it would be said to be an exciting cause, as the resulting

flatfoot would be produced by the immediate displacement of bones at the time of the injury, or as soon as the patient put any weight on the foot.

This calls to mind an interesting case. A young man sustained a severe blow on the instep by one end of a heavy steel rail as it was being unloaded from a wagon. The injury was so severe that a fracture was suspected and he was unable to use the foot for some days. After the acute symptoms had subsided and he was about again, he suffered from continuous pain in the region of the astragalo-scaphoid articulation when standing or walking. There was no sign of breaking down of the arch. The interesting point is that the pain was entirely relieved by the application of a steel ankle-plate. While there was no appreciable degree of flatfoot present, the history of the injury and the constant pain in the foot while in use led us to suspect a beginning breaking down of the arch, and no doubt this condition would have soon manifested itself if he had been allowed to go without proper mechanical treatment.

Shaffer* holds that the most frequent cause of flatfoot is found in a shortened gastrocnemius (the condition present in non-deforming club-foot), in that it does not allow the heel to quite come down to the ground, and thus permit of the full normal flexion and extension motion at the ankle, around what he terms the "astragalar arc;" and since it cannot occur here, the plantar tissues, which are put constantly on the stretch, yield in time, and "vicarious motion" takes place at the medio-tarsal joint. Briefly, the shortened gastrocnemius leads to a breaking down of the plantar tissues, which, in turn, allow the formation of a flatfoot. The mechanism of production is carefully and minutely considered, and a course of treatment recommended, *i.e.*, gradual stretching of the shortened muscles daily by means of a modified traction-shoe, which not only pulls the os calcis downwards and forwards, but pushes the astragalus and scaphoid upwards and backwards. In the interval, an ankle-support is worn, and at night a simple apparatus, which adducts the foot and holds the heel down. Excellent results are claimed for this method.

Within a few days a case illustrating this variety presented

* *N. Y. Med. Jour.*, May 29, 1897, pp. 717-721.

itself to the out-patient department of the Hahnemann Hospital. A young man, 19 years of age, a varnisher by profession, complained of continuous pain in the foot during the day, with stiffness on rising in the morning, and no history of any injury. Examination revealed a typical non-deforming club-foot, exaggerated arch, hyper-extension of the toes, a shortened gastrocnemius, with flexion scarcely to a right-angle, and some tenderness on pressure at the astragalo-scaphoid articulation. Most of the pain, however, was in the forepart of the foot, sometimes on the dorsum, but usually on the plantar surface.

Another and frequent predisposing cause of flatfoot is to be found in improper shoes, either narrow-toed or too tight, which develop corns, bunions or in-grown nails, and cause the patient to walk with the foot turned out—the weak position—in order to avoid the pain coincident to flexion of the toes, or the cumbersome, unyielding shoe of workingmen, which weakens the muscles and ligaments by holding the foot in a vise, as it were, and doing away with the normal motion at the ankle, medio-tarsal joint and toes, the tissues losing their tonicity through non-use; the arch then, under the influence of overwork or injury, becomes overstrained, and consequently flatfoot may develop.

The affection is, as a rule, easily recognized. Constant pain and discomfort about the arch of the foot, aggravated by use, especially going up or down stairs, with tenderness in the region of the astragalo-scaphoid articulation, are perhaps the earliest symptoms. The arch may appear normal or the foot may be flat. It must be remembered, however, that the amount of pain stands in no direct relation to the amount of deformity present; thus many patients whose feet present no appreciable deviation from the normal are great sufferers from pain, while cases with marked deformity are remarkably free from it. Again, the pain is not always referred to the same locality, while the characteristic pain is found in the region of the inner half of the medio-tarsal joint; yet in some cases it is situated about the outer half of this joint, while in others it is beneath the external malleolus, or in the metatarso-phalangeal joint of the big toe; and, lastly, there may be vague pains felt across the anterior part of the foot, in the sole, extending to the calf,

and even up the thigh. At times the pain, accompanied by redness and swelling, is worse in damp weather, which would lead a casual observer to uselessly treat the patient medicinally for rheumatism. I have in mind such a case, a policeman, with typical flatfoot, who was treated unsuccessfully for rheumatism of the feet for a long time. He was constantly becoming worse, and finally got to such a state that he could hardly attend to his duties. The condition being recognized, proper steel-supports afforded immediate relief. It is well to remember that rheumatism is rarely confined to one member or joint; persistent local pain in the feet invariably calls for local treatment for deformity present. Medicinal treatment can only do harm by wasting valuable time, and allowing the condition to become more and more aggravated. In more advanced cases, stiffness of the feet on rising in the morning, or after sitting, or cramps at night in the feet or calves are present, and are said to indicate beginning changes in the bones. Often there is found swelling of the feet, with excessive sweating. The inner arch of the foot is lowered, varying in degree, according as to whether the trouble is recent or of long standing. In typical cases there is a marked projection on the inner surface of the foot, below the internal malleolus, corresponding to the displaced astragalus and scaphoid bone, which may even touch the ground. The line of the foot on the inner side, instead of being concave, is convex, with an abnormal concavity of the outer border; the foot appears lengthened, broadened in shape and abducted; the big toe appears to be straightened out, so that it lies on the ground, or at times is held slightly plantar flexed (rarely dorsally flexed), and any attempt at further flexion is attended with excruciating pain. It must be remembered that it is not necessary to have deformity in order to make a diagnosis of flatfoot. When the affection is in its incipency, there may be no deformity present, yet the constant local pain, weakness or discomfort is such a characteristic symptom of flatfoot, and so difficult to account for from any other cause, that to one who is on the lookout there should be no hesitancy in recognizing the condition present, and, what is more important, at once instituting local mechanical treatment for its relief.

In the matter of treatment, much has been accomplished

within the last ten years. As the mechanism of production of the deformity has become better understood, the treatment has been revolutionized and simplified until, at the present writing, we may say that it has almost reached the acme of perfection. Perhaps no affection of equal importance will yield such gratifying results under persistent treatment. Whitman* goes so far as to say that "a radical cure is possible in all recent cases of flatfoot; and relief of pain, and to a great extent of deformity, may be assured in every case."

As a matter of convenience in treatment, all cases of flat-foot are divided into two classes: first, that in which the foot can be replaced in its proper position, and whose movements are free, and not limited by muscular spasm or adhesions; and second, that class in which reduction by manipulation is impossible.

The treatment of the first class is very simple. An efficient support which will hold the arch in its correct position, a proper shoe, exercises which will strengthen the weakened muscles, and a careful avoidance by the patient of faulty positions in walking and standing, are sufficient to give relief. The best support is a steel plate worn inside the shoe, which holds up the arch, and tends to throw the weight of the body on the outer arch by elevating the inner side of the foot. The patient should be instructed to walk with the foot pointed straight ahead, not turned outward as so many persons do. In this way the toes, being in front of the body, must be walked over, and the weight of the body is lifted at each step by muscular contraction. If the toes are turned out, then the body weight comes first on the heel, and is then thrown on the ligaments of the inner arch, the weakest point of the foot. This part of the treatment accomplishes a twofold purpose: it places the foot in the correct position, and the strongest, and at the same time brings into active use the weakened muscles by means of the best exercises at our command.

The latter can, in addition, be supplemented by others, to be taken at regular frequent intervals, such as rising on tiptoe, circumduction of the foot, and walking on the outer edge of the foot. These exercises are best done without shoes or

* *N. Y. Med. Jour.*, February 27, 1892.

stockings. The shoe should be broad enough in the sole to support the foot, with an inward twist, and lots of room for the big toe. In very mild cases the inner side of the sole may be built up after the method of Thomas, with a view of throwing the weight of the body on the outer border of the foot, producing a slight degree of adduction, and the counters can be thickened so as to give the arch some support. When used alone, however, without braces, it is doubtful whether this method does any good, as the foot can easily move inside the shoe and assume its former vicious position.

The treatment of the second class of cases is somewhat more complicated. In addition to the displacement we have to overcome inflammatory adhesions and muscular spasms. The treatment should be carried out according to the following principles laid down by Whitman :

1. forcible reduction and over-correction of the deformity.
2. A temporary support to prevent relapse.
3. A proper shoe.
4. Manipulation to stretch contracted and shortened tissues.
5. Exercises to strengthen weakened muscles.
6. A re-education of the patient in the proper manner of walking and supporting weights.

The patient is placed under the influence of ether, and adhesions broken up by forcibly moving the foot in all directions. It is then brought around into an over-corrected position, *i.e.*, extreme adduction and slightly extended, and so held by the application of a plaster-of-Paris bandage. The after symptoms are usually slight, and the patient is able as a rule to walk about on the following day. At the end of a week or ten days the bandages are removed and a steel brace substituted, with the foot in the corrected position. This brace is best fitted over a plaster cast. It is not necessary to reproduce the whole foot. The patient is seated in a chair and the foot, with the sole well oiled, is allowed to sink into a quantity of plaster cream, previously prepared in a shallow tray and placed on the ground in front of the patient. The outer border of the foot should be straight, and the ball of the toe pressed down until it touches the floor; a small quantity of plaster cream may be added to the inner surface, so as to obtain a better impression of the arch. The toes are left out.

When the plaster has hardened sufficiently a thin layer of vaseline is spread over its upper surface, and the form filled in with more cream of the same consistency. When the outer shell is removed a perfect reproduction of the foot remains, which can be further changed by scraping away any remaining projection on the inner side, and deepening the inner and outer arches, so as to make it resemble more closely a normal foot. This cast is then sent to the instrument-makers, reproduced in iron, and finally a thin steel-support moulded over it which fits the foot perfectly. The latter should be fashioned after the pattern first used by Whitman, *i.e.*, extend from the centre of the heel to a point just behind the ball of the great toe, curving up over the inner arch to just below and a little in front of the internal malleolus, corresponding to the astragalo-scaphoid joint, with an outer arm having a short upward curve opposite the calcaneo-cuboid joint. No covering of any kind is necessary. When properly made the brace can be worn inside the shoe without the slightest amount of discomfort, affords the weakened arch the best kind of support, prevents abduction, and does not in any way interfere with normal motion. It is by far the most satisfactory brace for flatfoot at our command. There are a number of others on the market, but none of them meet the requirements of the condition as well. While the brace is being prepared for the patient the foot is placed back again in the plaster bandage, which is continued for from one to three weeks, according to the severity of the case and the ease with which it yields to treatment. After the brace has been applied the patient must have impressed upon him the importance of assuming a correct attitude in walking, standing, etc. Under no circumstances must he go back to the old way of walking with the feet everted; they must be kept straight; it is even better to have a slight degree of "pigeon-toe" than too much outward turning. In conjunction with the mechanical treatment, exercises to strengthen the weakened muscles must be prescribed, so that the foot may be permanently held in the corrected position. These have already been mentioned. The most efficacious is a brisk walk with the feet in the proper attitude. In persistent cases a great deal can be done towards restoring the lost power of adduction by manipulative treatment. Briefly, it consists of gradually bringing the foot around

into a position of adduction by steady pressure exerted by the surgeon daily, and followed immediately by such exercises on the part of the patient as tend to adduct the foot, flex the toes, and contract the plantar muscles. To render the tissues more yielding, the foot may be previously immersed in hot water for a few minutes, then vigorously rubbed. As a rule, a cure can be effected and the brace be dispensed with at the end of six months, although very frequently all symptoms have disappeared long before this. The exercises and manipulative treatment are carried out till the foot is free from pain and unembarrassed in its movements.

Of the operations for the relief of flatfoot may be mentioned, first, those of Golding, Bird, Ogston, Hare, and others, which have for their purpose the destruction of the medio-tarsal joint, and that of Trendelenberg, supra-malleolar osteotomy, producing artificial bow-legs, with the view of throwing the weight of the body on the outer arch.

SOME COMMENTS ON THE PRESENT EPIDEMIC OF TYPHOID FEVER.

BY EDWARD R. SNADER, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society, County of Philadelphia, April 13, 1899.)

WHILE the unfortunate dwellers in the poetically-named City of Brotherly Love have, as we have the poor, typhoid fever always with us, as a continuous, perennial, more or less mild endemic, we are also cursed with occasional severe epidemic outbreaks in midwinter or early spring. There can be no mystery about this when we recall the condition of our water-supply. Philadelphia will hardly be puffed up with pride at the enviable reputation she is gaining of being the only big city in the United States that is generous enough to furnish a town-lot and a coal-mine in solution with every drink.

The present epidemic presents some features of interest to us as physicians. Although the constant presence of typhoid fever with us has almost benumbed us mentally to the cause always present in our water-pipes, and we have almost come to regard typhoid fever as something belonging to Philadelphia,

without which Philadelphia would not be Philadelphia, we cannot but know that the present epidemic is a severe and fatal one. I have consulted no statistics in order to make this statement, but have relied upon my personal experience and that of professional friends, who have had a wide experience with the present epidemic, as well as in other periods when the disease has been more than commonly prevalent. By "severe" I mean, not only that a large number of cases presented grave symptoms, but also that complications were more numerous and varied, and that a greater average of cases ended fatally. As a rule, too, cases give the doctor more anxiety. Many a physician who, in the conduct of typhoid ordinarily feels perfectly sure of his ground, has had the keenest apprehension, not only regarding complications, but the ultimate outcome. The spurs won in battles with typhoid fever in other epidemics have had the gilt and shine taken off them this year. Few, indeed, are those who have not had fatalities. In general, too, the typhoids of 1899 have lasted longer.

Onset.—In a fair number the onset has been sudden, prodromes, if any, existing only for twenty-four hours. Sometimes decided chills have ushered in the malady. We all know that enteric fever only exceptionally starts suddenly, but it seems to have occurred with great comparative frequency during our present siege. This feature of the onset increases the difficulties of diagnosis, makes one delay in giving a positive opinion of the exact nature of the malady, and makes us hesitate in regard to our procedures as to diet, hygiene and sanitation.

Temperature.—The temperature curves are enough to make Wunderlich rise up in horrified protest at the awful desecration of his typical temperature curve. He certainly could not have dreamed of Philadelphia typhoid fever. Wunderlich's curves were very raggedly represented. Temperature ranges of 105° F. and 106° F. were not uncommon either at the outset, in the middle period, or towards the close. But greater anomaly still is typhoid fever without any fever, if you will excuse the bull. I have seen cases, presenting a moderate elevation for the first twenty-four or forty-eight hours, after that present no rise in temperature from that time on until convalescence, three to four weeks later. Some of these cases had the "pea-soup"

diarrhœa, some had so-called bilious stools, and some were constipated. One case, characterized by a sub-normal temperature throughout ($96\frac{1}{2}^{\circ}$ F. to $97\frac{1}{2}^{\circ}$ F.) gave the Widal reaction, had enlarged spleen, and recovered, after a relapse. The fact, too, that little improvement took place until after the twenty-first day was taken as evidence of typhoid fever. Some cases presented decided remissions and accessions of fever, closely simulating remittents. Pure grippe, too, had these malaria-like oscillations, as well as the typhoids, if we may so call them.

A single effort only, and that unsuccessfully, was made to secure the Widal reaction in some of these cases. The effort, however, was not persisted in, for while I cannot but regard the Widal reaction as of some value in the diagnosis of typhoid fever, the absence of the reaction is not proof positive that typhoid fever does not exist. Besides, the technique of procedure is still in the experimental stage, and we shall have to wait a while longer before the exact value of the reaction is fully and authoritatively established. Its appearance, too, so late in the disease seriously militates against its value as a diagnostic criterion. While I have before seen afebrile cases of enteric fever, it has mostly but not invariably been in persons who had previously had typhoid fever, maybe years before. I cannot escape the conviction, however, that most, if not all, of the class of cases—the afebrile ones I am now speaking of—are examples of mixed infection, *i.e.*, la grippe and typhoid fever, the poisons of the two diseases in some as yet unknown way modifying each other, sometimes increasing the danger from the dominant malady and sometimes modifying the joint processes favorably as a whole. You have all witnessed the wonderful and mysterious temperature- gyrations in certain cases of la grippe—now a wonderfully high temperature without corresponding febrile symptoms, and now a very low range of the temperature without any symptoms of collapse. These temperature anomalies have convinced me, until investigation reveals a more tenable position, that la grippe influences, in some cases at least, the thermic centre in the brain. Upon this perhaps crude hypothesis I have attempted to account, to myself at least, for this unusual class of cases.

The Extra-Epidemic Influence—La Grippe.—Running all through the diseases we have encountered this year, since the

advent of influenza, has been a thread of symptoms or conditions that suggest to us the strong influence over all acutely-prevailing maladies of the *la grippe* poison. Running through our typhoids this thread has become a double-twisted rope. This "mixed" factor has much to do with the slow progress toward recovery manifested by many cases, and of anomalous progresses in others. Besides this thread, however, you have all seen cases that have started off in a sharp, distinct and unquestionable attack of *la grippe*, particularly of the intestinal form, that, during convalescence or before, developed typhoid fever. This kind of an attack is, or may be, of the mixed infection type, or the enteric fever may have become engrafted on the *grippe*. This class of cases, according to my own experience and common report, furnishes the greatest number of fatalities. Patients so attacked do not necessarily seem very bad after the preliminary scurry of temperature, and some at least pursue an apparently favorable course until late in the second week or toward the close of the third, when they develop intestinal hæmorrhage or become septic. I have been able to account for the greater prevalence of bowel bleeding on the theory, which may be wholly incorrect, that the preceding or accompanying grip, by virtue of its pronounced effect upon mucous membranes, so irritates the glandular structures in the intestines as to render them especially vulnerable to the typhoid poison, and enables the greater area of affected mucous membrane to take in a greater dose of the enteric fever poison.

I have observed in some individuals suffering from grippal bronchitis, who could not raise the morbid products of inflammation up far enough to expectorate, and have been compelled to swallow the sputa, taken suddenly with a severe diarrhœa, becoming later, in some instances at least, almost dysenteric in character; in point of fact, such sharp intestinal attacks of *la grippe* have occurred, too, without involvement of other mucous membranes. I know, therefore, that the *grippe* mucus is exceedingly acid and irritating, so much so that the products of a sneeze accidentally coming in contact with furniture will remove the varnish therefrom, and it seemed quite rational to me, in the absence of more specific information, to theorize that an intestinal canal affected with *la grippe* would furnish a bed of roses for the development and further propagation of

the typhoid ptomaines, and measurably accounted for an increased depth and intensity of the ulcerative process in Peyer's patches and the other intestinal structures, and hence for the greater frequency of fatal hæmorrhage in these mixed cases, and greater facility for systemic absorption and consequent autotoxæmia and sepsis.

Another group of cases, perhaps coming properly under the caption of mixed infection, is that tolerably numerous class that start off at once as a severe bilious, or rather sero-bilious, bowel diarrhœa, possessing very few of the classical catarrhal, but many of the nervous, symptoms of grippe, and yet indistinguishable from grippe, that, after two or three days, or, in some instances, a week or ten days, settle down to a steady gait of two or three movements a day, which are always more or less sero-bilious in character. Some of these cases show decided prostration, have the "spots," and proceed to convalesce on the twenty-first or twenty-third day, and are sometimes six weeks in recovering. If these cases are not mixed infection of grippe and typhoid, you will have to burden medical literature with the description of a new disease, which might be appropriately designated as "Philadelphia-Water High-Bred (Hybrid) Fever," for want of a more appropriate title. In this class of cases the diagnosis is exceedingly difficult, because some of them, presenting all the preliminary phenomena of the cases that take three or more weeks to show signs of returning health, persist in getting fairly well in a week. Many of these patient show spots indistinguishable from the typical petechia of enteric fever. I do not care here to open the discussion of the question of "abortive typhoid," but if these cases are actually typhoid, we are certainly approaching the medical millennium in giant strides, and floated there, too, on the swelling bosom of our dear, delightful, poetic Schuylkill, that has been so shamefully abused because it has periods when it claims kinship with the Yellow Tiber.

Here's acquired immunity for you with a vengeance. If these cases are bastard typhoids, we will soon be able to take our water of solid clay, with coal dressings, with its germ and chemical sauce, and be so hardened that we will be over typhoid, if we can get it at all, in a space of time no longer than from early morn to dewy eve.

The probabilities are that some of these cases are a mixed infection of influenza and enteric fever from the very start, and that some others are pure, unadulterated grippe of the intestinal variety. I am somewhat helped in the problem of making a diagnosis in these cases by an examination of the spleen and liver. If I find the spleen enlarged, and the liver, too, in some instances, I am more sure of my diagnosis. I know that grippe attacks every organ in the body, and is so greedy that it is reaching outside the organism, but I have not yet found that la grippe affects the spleen in the same way as does typhoid fever; and I shall, therefore, hold on to my little differential point until Widal's reaction shows earlier, or some other diagnostic data are evolved from our accumulating experience.

The "Spots."—The fact that spots occur in some cases pursuing the general course of la grippe will not be at all surprising to those physicians who are very skeptical as to the existence of absolutely pathognomonic signs in disease. Personally, while appreciating to the full the enormous value of the rose-colored spots in the diagnosis of certain obscure cases of enteric fever, I have never felt that their presence decisively settled the diagnosis either for or against typhoid fever, although their presence is most comforting to most practitioners. Certain it is that I have seen these spots in maladies the very obverse of typhoid fever. Spots not differentiable from those of typhoid fever, appearing in crops, disappearing on pressure and reappearing shortly after the pressure was removed, have assuredly been present in some of the cases of la grippe this season. Whether these were cases of typhoid fever masquerading as la grippe, the grippe element being so dominant as to conquer the enteric fever element, and by virtue of this dominance so modifying the poison of typhoid fever and preventing the development and evolution of the regular form of typhoid, is a moot point, and will require prolonged investigation and not a few dead-house observations to definitely settle. I am sure a discussion of the subject of the value of the eruption appearing, particularly in typhoid fever, will prove most interesting and profitable.

Aside from this excursion into debatable ground, some other points are of interest regarding the enteric rash. The rashes in undoubted cases of typhoid fever this year have, so far as

my individual experience goes, been much more profuse than is usually observed. The spots have been very large in size, slower to disappear on pressure, possibly on account of their greater size, and coalescence occurred in quite a number. The roseola invaded not only the abdomen, but the chest, back, arms, and even the face, in one instance. The rash in some rare examples was so profuse, so coalesced, so crescentically arranged, and the patches so large, as to closely simulate measles. In fact, in one case, seen with a fellow-practitioner, these characters were so marked as to lead to a diagnosis of measles. The presence of the typhoid state, the "pea-soup" dejections, the finding of the Widal reaction, as well as the subsequent clinical course of the case, proved it to be a case of typhoid fever beyond peradventure.

I have seen very little, in fact I do not now recall a single instance, of the miliary rash often noted in enteric fever, as well as in other febrile cases. Purpuric spots and large purple stains of the skin were noted in the septic cases.

Complications.—While, in the sphere of the nervous system, coma, typhomania, coma vigil and headache of an excruciating type have been more than usually severe during the present rage of the fever, I have been struck by the large number of cases of otitis medias and painful pharyngites I have encountered.

I have noted two cases of parotitis, and have heard of others. This complication, generally thought to be a grave one, I have never before seen.

In the respiratory sphere, in addition to a larger number of hypostatic congestions, broncho-pneumonias occurred quite frequently; but I have observed croupous pneumonias as complicating features far more frequently than catarrhal lung inflammations. The bronchitis in some instances was quite severe, affecting the membrane of the middle-sized tubes, with difficult coughs, almost whooping in character, having what might be called a grippal intonation. In some instances, however, the bronchitis that ordinarily marks typhoid fever had to be carefully ausculted for in order to determine its existence, so meager and indecisive were the symptoms.

Outside the heart weakness we naturally anticipate encountering in the terminal stages of regular typhoid fever, I have seen

two cases of septic myocarditis, a grave condition I have not noted as occurring in any case of typhoid fever seen by me in the last seven years at least. Endocarditis of the ordinary variety I have seen several times, although I well know that endocarditis is generally regarded as rather rare in ordinary typhoids.

One very sad case of ulcerative endocarditis was seen by me, appearing just as the patient had reached the ordinary period for convalescence. The septic myocardites appeared early in the disease.

The intestinal canal accidents, however, were more numerous than I have ever known them to be, and conversations with friends impress me the more forcibly with this point. Peritonitis apparently without perforation, and perforation without hæmorrhage, has been noted, and bowel bleeding has been unquestionably frequent. Both venous and arterial hæmorrhages have been, in many instances, uncontrollable and fatal. Ordinarily, in previous epidemics, a slowly-evolved oozing, or even a fair flow of venous blood, did not prove so intractable as in this season's cases. Many of the red-blood bleedings have been severe and repeated, and this cause alone accounts for an unusual number of fatalities.

Other comparatively rare complications have been rectal and sigmoid impactions of fecal material, and one case during convalescence developed an incomplete obstruction from partial intussusception, the ultimate termination of which I do not know.

Miscellaneous Observations.—A noticeable feature of this epidemic, too, has been the large number of infants and children under puberty who have been affected.

Diarrhœa has been very frequent, constipation being, indeed, a rarity, whereas in the previous epidemics within my knowledge I had almost come to regard constipation as a much more characteristic of Philadelphia typhoid fever than diarrhœa.

In some cases of dangerous high temperature the cold spongings seemed singularly ineffective in reducing the fever. In a few cases the fever seemed to drop to the safety line of its own volition. The skin surfaces seemed peculiarly irresponsive to baths.

In presenting this paper for your consideration I am only too well aware that one swallow does not make a summer, and that the observations of any one man must be received *cum grano salis*. I fully realize that there are "others," and it is those others I am now gunning for. I am willing to be revised and re-edited by the wider experience of the combined membership of the Society. My theories to account for the severity of the present epidemic are homemade and homespun, and are simply the result of an attempt to rationally account for some of the phenomena of the typhoid fever of the present time until the entire profession shall have arrived at a more satisfactory and generally acceptable view.

I do not mean to imply by this paper that all our enteric fevers of this epidemic are atypical, by any means. There were many, very many, true to the classical description. It is true, too, that in other epidemics I have encountered just as anomalous temperature- gyrations as in this one, seen hybrid cases, and cases so mild as to make one almost doubt the existence of the disease, and I have accounted for these cases to myself on the theory of individual reaction to the typhoid poison. In other words, some subjects had less pabulum and more resistance than others. Analogous deviations from the norm of disease are daily seen in all maladies of the infectious type. Notwithstanding the fact that all the unusual cases may perhaps be accounted for on this theory, I am still of opinion that the typhoids of this year were modified by la grippe, and that la grippe, when present in a given case of typhoid, was modified by that typhoid.

If you totally disagree with me you have only to blame the Chairman of the Section, who inveigled me into writing the paper, and who, with my fellow-members of the bureau, is too busy treating typhoid to write about it. My special instructions, also, were to raise a row.

CROTON TIGLIUM IN ECZEMA.—Dr. Goullon, in a woman at the climacteric, who from her youth had been sickly and as a child had suffered much from scrofulous inflammation of the eyes and a continuous otorrhœa, and who at the least exertion would easily perspire with rheumatoid pains, particularly at night, was distressed by weeping patches of eczema in her armpits, with small ulcers. Frequently these patches would extend into her face. Croton tiglium caused them wholly to disappear. No attenuation stated.—*Leipziger Populære Zeitschrift fuer Homœopathie*, Nos. 19 and 20, 1898.

THE EXTERNAL USE OF IODINE.

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(Read before the Homœopathic Medical Society of the County of New York.)

I CAN best illustrate my views of the external use of iodine by citing a few cases in which it has been employed successfully.

Last summer a patient suffered from discomfort in walking, the pain being in the anterior tibial muscle. The discomfort increased for several days, becoming, at last, severe enough to demand attention. On examination, I found the leg, from the knee to the ankle, fiery red, swollen, and tender to pressure. The tenderness extended up the inner side of the thigh to the inguinal glands. This was evidently an infective lymphangitis, and the source of infection was found in a cut on the small toe. The toe was swollen, red, and tender. The whole leg was now painted with tincture of iodine, and an especial coat painted over the peccant toe. In six hours the patient could walk with more comfort. In twenty-four hours the relief was marked. The leg was painted once daily for ten days, and by the seventh day was practically well.

This case illustrates the sphere in which iodine acts with certainty and promptness—infected wounds, and their extension to the lymphatics and the surrounding cellular tissue.

When I find a scratch or cut on my hands after an autopsy or after handling pathological material, I cover the raw surface with strong tincture of iodine, and paint the skin for some distance around the wound. This is the practice in several large hospitals in this city, and I have never known of an instance of necrogenic infection when this precaution had been taken. Sometimes a slight scratch will pass unnoticed for several days, and a small festering sore will appear. The thorough application of tincture of iodine removes the soreness and swelling, and healing occurs without delay. In the treatment of erysipelas, local application of iodine is of more service than any other measure.

Bear in mind that iodine is useful not only as an application to the seat of infection, but also to the resulting distant inflammations. Thus we find that iodine has long held a place in gynæcological practice as a local application for the cure of pelvic cellulitis, parametritis, with soft, recent exudates. These conditions are almost always the result of infective processes. In acute mastitis, too, especially puerperal mastitis, we have an instance of severe distant inflammation with an insignificant point of infection about the nipple. The tincture of iodine, painted on and around such an inflamed breast, will check the inflammation more promptly than any other measure known to me. The effectiveness of iodine in infective inflammations in general is probably reinforced by its affinity for the breast tissue.

The local use of iodine in the throat and nose, in the form of Lugol's solution, is well known to you all. It quickly relieves acute inflammatory conditions. Tincture of iodine painted on the outside of the neck will soak into the throat and relieve almost as promptly as when applied to the mucous membrane.

Iodine has an especial affinity for the larynx. A measure of great value in croup, especially the spasmodic form, is the painting of iodine on the skin over the throat, no matter what remedy is given internally. Iodine is also of value in bronchial catarrhal states—the more acute the better—when painted over the chest. Its action is not as prompt as with laryngeal and tracheal disorders, perhaps because it cannot reach the parts so easily. In pneumonia, also, iodine applications have distinct value. It is often regarded as a simple counterirritant, to redden or blister; but I think this an erroneous view of its utility. The object in this case is not to blister, but to saturate the chest tissues with the drug to obtain its specific anti-phlogistic effect. Of abdominal troubles, many a case of obscure pain will disappear after a course of iodine painting on the abdomen.

Iodine has an especial affinity for the lymphatic tissue, and shows its power by its ability to reduce swollen lymph-glands—cervical, inguinal, abdominal or others. Here, a word of caution is needful. A group of lymph-glands may be swollen with simple inflammatory congestion and exudation. This con-

dition will be cured easily by the local painting with iodine. On the other hand, the swelling may be due to a tuberculosis with caseation, or the inflammatory exudates may have degenerated into hyaline or waxy masses, or organized into fibrous tissue. Such a condition will be rarely, if ever, influenced by iodine or any other remedy. The same principles apply to the treatment of goitre. A simple inflammatory swelling of the thyroid, either acute or chronic, is curable by local applications of iodine, as shown by the many cures recorded in our literature. But the large leathery thyroids, with masses of calcified fibrous tissue; cysts containing gummy colloid which cannot be absorbed; cysts whose gristly walls will not collapse with any pressure less than that of a hand-screw—these goitres will not yield to the use of iodine externally or internally, nor to any other medicine.

There is one use of iodine which may be regarded as a local application, and that is its use in cases of excessive vomiting. It was Rademacher who first discovered this property of iodine, which led him to class iodine as a specific stomach remedy. His method of administration was to mix twenty drops of the tincture in eight ounces of water, and give a teaspoonful every half-hour or so. I have not been able to determine in my own mind the principle of action of iodine in these cases. It may be homœopathic, for vomiting appears as a prominent pathogenetic symptom of iodine; but this is true of every irritant drug in the *materia medica*, and not every drug that causes vomiting possesses also the specific curative effect of iodine. In vomiting of gastric origin there are two remedies which are of greatest value; these are iodine and the chloride of lime.

A further local use of iodine is in parasitic diseases of the skin. Ringworm of the body is rapidly cured by the use of the strong tincture. Ringworm of the scalp, which is a tedious disease at the best, finds in iodine one of the most useful remedies.

In the use of iodine upon the skin care must be taken not to use too strong a solution. The officinal tincture is too strong, except as a parasiticide or for infected wounds. I use a mixture of equal parts of alcohol and the tincture of iodine. For infants, the tincture should be diluted with three to four times its bulk of alcohol.

The only damage possible by the local use of iodine is in those few patients on whose skin iodine produces a papular eruption or an œdematous swelling. In the use of iodine on hundreds of cases during the last ten years, I have only met one such case, and therefore judge that they are rare.

I have brought this subject of iodine before you for two reasons: first, because I wish to present my experience with a valuable therapeutic agent; secondly, that I may persuade some of our number that the local use of iodine is an efficient and valuable procedure. We homœopaths have great distrust of local applications in general. This distrust is justified, because the local application is oftentimes the resource of ignorant and bungling therapeutics. But, in our general attitude of antagonism toward the local application, we are apt unwittingly to close our eyes to the value of those applications that possess real curative powers. I wish to present to you the platform that the homœopath is not only justified in using local applications of iodine, but that he is morally bound to be familiar with its curative power, and to use it locally, as he does his remedies, in what appears to him to be an appropriate case.

ANGINA PECTORIS (STENOCARDIA).

BY E. FORNIAS, M.D., PHILADELPHIA.

PAROXYSMAL affection, characterized by a retro-sternal pain, of variable intensity and of *stabbing character*, usually radiating towards the left shoulder and arm, with a sensation of *numbness* and *tingling in the fingers*, and almost always associated with the most *intense anxiety* and *dread of impending death*.

SYMPTOMATOGRAPHY.—ATTACK, recurring, without any appreciable cause, or brought about by an excitement of the pneumogastric, branch of the plexus, in its cardiac sphere (*emotion*), respiratory (*tobacco, walking against the wind*), gastric (*excesses at the table*).

PAIN, *retro-sternal, severe, sharp, stabbing*, having its maximum along the left border of the sternum, at the lower or middle portion of this bone; *radiating* into the neck or jaw (*cervical*

plexus), to the epigastrium and base of the thorax (*phrenic*), to the anus and testicles (*ilio-scrotal branches*), but principally to the left shoulder, arm and hand (*brachial plexus*), and to the last two fingers (*sphere of the cubital*); it invades rarely the two sides of the body, or travels in the inverse sense, that is, from the hand to the chest, as the *aura epileptica*.

ATTENDANTS OF THE PAIN.—A sensation of *numbness*, and *tingling* in the fingers of left hand, often accompanies the pain. Sensation of strangulation (*pneumogastric*), of *thoracic constriction*, of suffocation, but breathing is not really obstructed. The *action of the heart* is often *tumultuous* and associated with a feeling of *faintness*, *precordial anxiety* and *dread of impending death*. The *pulse* is ordinarily *retarded*, and *irregular* in case of *cardio-aortic* lesions. *Prostration*, *pallor*, *cold sweats*, *coldness of the extremities* (*gran sympathetic*). Consciousness remains unimpaired. No abnormal sounds are detected in the lungs. At the beginning of the attack the *patient clutches at the nearest object for support*. At the height of the attack there is *fixation of the body*; and *syncope* and *general convulsions* may supervene.

AFTER THE ATTACK, which early in the disease only lasts a few minutes, there are: *abundant emission of clear urine* (*urina spastica*), *gaseous eructations*, or *vomiting*, *swelling of the testicles*, and *general malaise*.

DURING THE INTERVALS, the health of the patient is good, or there may be embarrassed respiration, numbness of the left arm, and thoracic constriction, which occasionally are the only morbid manifestations of *false angina pectoris*.

ANGINA PECTORIS is a disease of middle life or advanced age, and is more common in men than in women. At first the paroxysms last only a few minutes, and recur only at long intervals. Gradually they lengthen and recur with increased frequency, being evoked not merely when walking, but when sitting or lying down, and at the slightest bodily exertion or mental anxiety. I think, however, that this breast-pang comes on mostly as a consequence of exertion, usually after the stomach is full, and especially when the heart muscle is most taxed, as in going up a hill or against the wind. Its symptoms present every degree of severity and duration; there are gradations of the pain from a sudden sharp twinge to a paroxysm of great agony.

Angina pectoris is sometimes *idiopathic*, *essential*, a *neuralgia of the cardiac plexus* (Peter), provoked, as stated above, by the abuse of tobacco, tea, and coffee; or associated to a *cerebro-cardiac neuropathy* (Krishaber), to *epilepsy*, to *hysteria*, to *diabetes* (Vergely) and to *Bright's disease* (Dieulafoy). More frequently it is *symptomatic*, *secondary*; a *neuritis of the cardiac plexus* (Peter), with or without concomitant neuritis of the phrenic nerves (*internal respiratory nerve which goes to the diaphragm*), caused by all lesions which can affect this plexus, such as ossification of the costal cartilages or of the coronary arteries, obliteration or narrowing of these arteries (Potain), chronic aortitis (Peter), aneurism of the aorta, pericarditis, or cardio-aortic lesions. It may be a manifestation of *gout*, *rheumatism* or *syphilis*, in which case is often provoked by lesions of the aorta or of the coronary arteries, the coronary arterio-sclerosis being possibly independent of the aortic lesions. The *gouty diathesis* may manifest itself by the angina, as it manifests itself by migraine or by asthmatic attacks (Dieulafoy). The *rheumatic diathesis* can likewise develop the *cardiac neuralgia*; sometimes the *angor pectoris* appears at the height of an attack of *acute articular rheumatism*, at other times it is only of a *rheumatic character*, the patient never having had the articular attack (Vignier). The coronary arterio-sclerosis of *syphilitic origin* is frequent enough the cause of *angina pectoris* (Hallopeau). It is probable that the acute and chronic lesions (aneurism of the aorta, brachio-bronchial adenopathy, pericarditis) *near the cardiac plexus* may become a cause of the angina (Jaccoud); sometimes the inflammation of the aortic wall invades the cardiac plexus, just as inflammation of the pericardium the phrenic nerve (Dieulafoy), and there are cases where the autopsy has demonstrated not only a congestion but an inflammation, a *neuritis of the cardiac plexus* (Lancereaux), with and without involvement of the *phrenic nerve* (Peter). But we must establish as a principle that whatever the cause of angina pectoris may be, the *cardiac plexus* and the cardiac nerves, which emanate from it, are the initial and principal seat of the symptoms. The entire *cardiac plexus* may participate in their production (branches of the pneumogastric, of the gran sympathetic and ganglia), and the richness of this plexus, the importance of the nerves which enter into its formation, and their numerous anastomoses, explain at once the gravity

and diversity of these symptoms. The *painful irradiations*, the *synesthesies*, modify the symptomatic expression of the attack. For the anguish, precordial pain, and syncope, we must inculpate the *pneumogastric* and *sympathetic branches*. The repercussion on the *brachial plexus*, and principally on the *cubital nerve*, accounts for the pain of the hand and little fingers. When the painful paroxysms are more extensive, the diversity of the pains is in relation with the nerves attacked by the neuralgia; so are made plain the sensations of strangulation and œsophagismus (*filaments of the pneumogastric*), the thoracic constriction, the pains in the diaphragmatic insertions (*phrenic nerve*); the pallor, the sweat, the prostration, the coldness of the extremities (*irradiations to the sympathetic*).

These are the most accepted opinions of many leading men of the day, but there are others, equally prominent, who do not seem to know what the pathology of angina pectoris is; whether a cramp of the heart muscle, a neuralgia of the cardiac plexus, or a paralysis of the myocardium from excessive arterial tension, due to constriction of the arterioles (Money). According to Carter the immediate pathological cause—*neuritis* or *neuralgia of the cardiac plexus*—is probably the same, only it is more severe in angina, the associated structural disease of the heart and vessels is generally more serious, and the condition of the system is less able to withstand the shock of an attack with impunity. For others there is no true *angor pectoris* but that due to an *organic* or *spasmodic narrowing of the coronary arteries* and to the *consecutive anæmia of the heart* (Huchard), the other varieties being *pseudo-anginas*. Sée also asserts that angina pectoris is the result of a *cardiac ischæmia*, whether the ischæmia be due to a *coronary arterio-sclerosis*, or to a bad functional action of the *coronaries*. And, finally, Dieulafoy, of Paris, whom I have frequently quoted, wisely contends that *angina pectoris* and its different varieties can be the result of multiple causes. In some cases, he states, *angor pectoris* seems to be a true *neuralgia*, independent of all appreciable lesion; the *neuralgia* is sometimes accompanied or substituted by a *neuritis*, and, frequently enough, it is associated to *lesions of the heart, of the aorta, but principally of the coronary arteries*. He believes that the *organic* or *spasmodic narrowing of the coronary arteries* is the immediate, essential cause of a great number of cases of *angina pectoris*, but

he also thinks that many cases of *simple cardiac neuralgia* may stir up the very syndrome constituting true angina, and, if desired, these cases can be placed under the category of *pseudo-anginas*. To this assertion I subscribe unconditionally, for in my practice I have had occasion to observe cases of both descriptions, to which I shall refer in the treatment.

The DIAGNOSIS of this affection does not, as a rule, present serious difficulties, the *sudden paroxysm*, *retro-sternal pain*, *anæsthesia dolorosa*, *fixation of the body*, *cardiac troubles* and *fear of impending death*, constitute a characteristic symptomatic ensemble, but the *painful irradiations* are sometimes so varied and extensive as to render it difficult. An important point to be remembered is that *pain* is not a common symptom of *organic heart disease*, except in lesions of the aortic orifice, when it may be troublesome. The regular performance of the *respiratory functions* suffices to distinguish the *anguish of angina* from *asthmatic dyspnœa*, which, among other distinctive signs, is accompanied by *arrest of respiration in inspiration*. This habitual integrity of the respiratory function, however, should not be taken as an absolute rule, for there are cases which, due to exhaustion of the *par-vagus*, exhibit, during and after the paroxysm, *pulmonary congestive phenomena* (Huchard). These accidents, which at times are accompanied by *gastric paresis*, should not astonish anyone, given the triple distribution of the pneumogastric.

Diaphragmatic pleurisy and *acute pericarditis* may provoke pains of *phrenic* and *cardio-plexus* origin, but there is fever and the symptoms persist after the attack. *Angina pectoris* has more extensive irradiations than *cervico-brachial* or *intercostal neuralgia*, which are limited to the tract of the nerves involved. The same may be said of *pleurodynia of the precordial region*. We should also bear in mind that *angor-pectoris* is often but a symptom; in fact, a *forerunner* of lesions of the aorta and mediastinum; it is frequently the initial sign of *aneurism of the aorta*, and such causes must be recognized in time. Then, again, there are cases which only exhibit one of the symptoms of the trouble, such as numbness and tingling of the left arm, pain limited to the little finger, sensation of constriction or distress in the region of the heart. But the true interest of the *diagnosis* rests upon the nature of the disease itself. We must ascertain whether we are dealing with an essential or symptomatic

angina. If the outset is sudden, in a subject still young, and brought about as the result of a violent emotion, menstrual suppression, persistent dyspepsia, or in an inveterate smoker, especially if the paroxysm occurs at night, makes slow progress and prolongs itself, we may reasonably consider it a *simple neuralgia of the cardiac plexus*; but if, on the other hand, the patient is advanced in years, suffers from atheromatous changes in the blood-vessels, percussion reveals a small dilatation of the arch of the aorta, and the retro-sternal pain persists during the intervals of the attack, then, no doubt, we have before us a case of symptomatic angina, associated with chronic aortitis.

The PROGNOSIS, of course, is more serious in symptomatic angina, where sudden death is frequent, than in essential angina, which is susceptible of cure. The patient may die suddenly from the pain (arrest of the heart by excitation of the par-vagum), or may succumb slowly from dyspnœa, cyanosis or coma.

If the table opposite should be taken as a guide, the first thing we learn is that *true angina pectoris* is usually associated with aortic or coronary lesions and incurable, while *pseudo-anginas* are always curable, if properly treated. We must know with what kind of angina we are to deal, and, in making the diagnosis, bear in mind the two important points mentioned above, namely, that *simple cardiac neuralgia* may provoke the very syndrome characteristic of *true angina pectoris*, and that pain is not a common symptom of *organic heart disease*, except in lesions of the aortic orifice.

As to the *treatment*, if we take the remedies employed in the reported cases, in the order of frequency, we have ARSENIC and ACONITE first in the list, followed by SPIGELIA, CACTUS, PULSATILLA, LYCOPODIUM, SULPHUR, NUX VOMICA, AURUM, TABAC., GLON., RHUS TOX. and LAUROCERASUS; and, indeed, the pathogenesis of these remedies furnishes abundant indications for the relief of *cardiac neuritis* and cure of *neuralgia of the cardiac plexus*. Of course, in a disease presenting so many painful and distressing symptoms, we should not wonder that young physicians of our school, in order to procure immediate relief for their patients, may be tempted to resort to any remedy extolled and recommended by our versatile opponents. To these neophytes I have only to say that the most recent old-school

Table Showing Treatment of Eight Cases.

Sex.	Age.	Diagnosis, Etc.	Treatment.	Termination
Female. (Single.)	71	NEURITIS OF CARDIAC PLEXUS. <i>Aortic lesion.</i> Had suffered from attacks of increasing severity for years.	R. SPIGELIA had been given by former physician. I gave CACTUS, TABAC. and ARSENIC. <i>Nitrate of amyl</i> , previously given, did more harm than good.	Death.
Male. (Clerk.) (Single.)	47	NEURITIS OF CARDIAC PLEXUS. <i>Coronary lesion.</i> Old-school origin. Terrible suffocating, with increased violence.	R. <i>Nitrate of amyl</i> had done no good. I tried it again and was sorry for it. Never gave it again. ACONITE and SPIGELIA during the attack. ARSENIC at the interval palliated the case for 3 months.	Death.
Male. (Clerk.) (Single.)	39	NEURALGIA OF CARDIAC PLEXUS. <i>No lesion.</i> Attack provoked by smoking or walking against the wind. Great deal of numbness and tingling in left-hand fingers.	R. ACONITE, NUX. V. and ARSENIC, with dropping of tobacco and a trip to Bermuda proved curative. Returned home enjoying good health, and remained so when last seen.	Lost track of the case.
Male. (Merchant.) (Married.)	56	NEURITIS OF CARDIAC PLEXUS. <i>Aortic lesion.</i> Frightful attacks, with radiations to diaphragmatic sections. Great fixation, could not tolerate advice or medicine during attack. Riding against wind brought on paroxysm.	R. AURUM did well first, then SPIGELIA, CACTUS, GLON., RHUS and LAUROC. Insisted on riding bicycle, and after 5 years of illness dropped dead, after a ride in the park.	Death.
Female. (Single.)	21	PSEUDO-ANGINA. Plethoric and dyspeptic. Excess at table brought on always attack, with painful radiations, vertigo, fainting, <i>anxiety and fear of death.</i> Fat and pastry disgreed.	R. ACONITE, PULSATILLA, LYCOP., SULPHUR and ARSENIC, according to symptoms, relieved condition, and under proper diet recovered entirely, and keeps well to the present time.	Recovery.
Male. (Politician.) (Married.)	27	PSEUDO-ANGINA. Bad teeth. Fermentative dyspepsia. Fond of pastry. Cold lunches, hasty eating and improper mastication cause of trouble. Little pain, but much numbness.	R. PULSATILLA, LYCOP., SULPHUR and ARSENIC, together with false teeth and change of diet and regimen effected cure, though once in a while runs to my office fearing the return of the attack.	Recovery.

Table Showing Treatment of Eight Cases.—Continued.

Sex.	Age.	Diagnosis, Etc.	Treatment.	Termination
Male. (Merchant.) (Married.)	65	NEURITIS OF CARDIAC PLEXUS. <i>Chronic aortitis.</i> Distressing attacks, with great fixation, ending in much belching, etc. Great smoker. Business worriment. Stubborn.	R. Former homœopathic physician treated him for dyspepsia first, then prescribed <i>nitro glycerine.</i> At my hands he received ACONITE and CACTUS, with gratifying results, and when he died was under ARSENIC.	Death.
Female. (Married.)	53	PSEUDO-ANGINA. Nervous temperament. <i>Gouty diathesis.</i> Acid dyspepsia. She is in constant fear of death and thinks she will die of heart disease, like her husband. Painful radiations to diaphragm. Depressed state of mind.	R. She had taken PULSATILLA, NUX V. and SULPHUR with relief, but there has been a marked improvement in the general condition during last year (1898) under LYCOPodium, with systematic exercise in the open air.	Under observation.

works on *diseases of the heart and aorta* keep on exhibiting the same degree of vacillation and uncertainty of former years, in their constant endeavor to find new curative agents to replace the discarded ones, or to revive those which were once abandoned as useless. In fact, allopathy has not had nor has anything better than we have to offer.

A review of the *clinical history of angina pectoris* shows that, apart from such stimulants as ammonia, wine, brandy; cutaneous revulsives, sinapisms, turpentine stupes, immersion baths, leeches, belladonna plaster worn constantly over the precordial region, and other crude means, we have in the record the *antiquated opium*, the *bygone Fowler's Solution*, the *old-fashioned quinine*, the *indispensable iodide of potassium*, the *irresistible morphia*, the *inhalations of ether and chloroform*, the *cigarettes of cannabis indica*, the *faradization of the par vagum*, *galvanic electricity* and *electro-magnetism*, which have been more or less discarded and replaced, first, by the world-renowned *nitrate of amyl inhalations*, and then by *trinitrine* or *nitro-glycerine* (our *glonoinum*), found very efficacious by some, very dangerous by others, until, finally, we find to-day leading authorities recommending, as safer and more effective agents, *exalgine*, *antipyrine*, *nitrate of sodium*, *tribromide of allyl* and *pyridine*.

Rather than to ramble in a labyrinth of the kind, I would advise the inexperienced to stick to our remedies, and bear in mind that, in this malady, rest is an essential therapeutic agent, especially cardiac rest, which should be obtained by removing all constriction in dress from the neck and abdomen, and abstaining from alcohol and tobacco. The influence of tobacco on the product of *angina pectoris* is not doubted any longer, and it is generally admitted that this poison once dissolved in the bronchial mucus goes directly to irritate the pneumogastric expansions; hence, common sense and prudence should prevent a patient courting a paroxysm, not only by the use of tobacco, but by walking against the wind, or struggling to ascend a mountain. The *prophylactic treatment* comprises, moreover, country life, with protection against wind, dampness and cold, and the patient should be regular and methodic in habits and free from all cares and emotions. Regular, systematic walks, without fatigue, are beneficial. All muscular exercise somewhat violent is proscribed, and we must insist on the bad effects of exaggerated motion of the left arm, frequent seat of the painful radiations, and which is, occasionally, even the starting-point of the pains. The meals should be substantial, but not abundant; it is preferable to eat little and often, than otherwise, in order not to tax the stomach, thus avoiding the attacks which often follow full meals, and principally a late evening dinner. This last meal should always be composed of light, easily digested food. A milk-diet for several days in succession may prove useful. An agreeable, salutary beverage is the juice of pineapple. In general, spiced meats, highly-seasoned dishes and stimulant drinks, as tea, coffee or fermented wines, should be avoided. Pure water, with a few drops of brandy at meal-time, is often grateful to the patient. The *dyspeptic troubles*, flatulence, eructations, pyrosis, gastralgia, vomiting, etc., when present, should be treated according to indications, and there may be cases requiring the washing of the stomach.

ADENOMA OF THE BREAST CURED BY PHYTOLACCA.—A tumor of the breast which was regarded as an adenoma was cured by phytolacca.—*Zeitschrift des Berliner Vereines Homœopathischer Aerzte*, bd. xvii., lft. 6.

BURNS AND SCALDS AND THEIR TREATMENT.

BY F. WALTER BRIERLY, M.S., M.D.

(A Senior Surgical Subclinic, Hahnemann Medical College, April 4, 1899.)

OUR first two cases this afternoon well illustrate the subject of burns and scalds. This first case, as you see, is a superficial scald, while the other is a deep and extensive burn, which is healing kindly. You are soon to go into active practice, and this subject may profitably claim our attention for a half hour.

Burns and scalds may be trivial, or they may be the most horrible of accidents. Even those of a superficial nature and limited area give rise to intense pain, while the severer forms not only drive the poor unfortunate crazy from suffering, but quickly kill him. Burns are generally understood to be injuries done by contact with hot solids or burning substances, while scalds are caused by hot fluids. The injuries from each are similar, and are very much like those produced by strong acids and alkalies, and by intense cold, as from contact with liquefied air.

Antisepsis has revised the classification made by Dupuytren, with its six degrees of intensity, and for therapeutic and prognostic purposes but three classes of burns and scalds need be made: (1) Those producing a simple erythema; (2) those which cause the formation of vesicles; and (3) those which cause destruction of the true skin and underlying tissues. The prognosis as to life in burns and scalds depends upon the extent and depth of the injury and the ability of the patient to resist shock. A mere hyperæmia of two-thirds of the surface of the body usually results in death, while the destruction of one-third of the skin is fatal. The most painful burns are those which expose, without destroying, the nerve-endings in the skin. In all burns and scalds of any intensity the agonizing pain is soon followed by profound shock. This shock may result in twenty-four or forty-eight hours in death, or reaction may follow, bringing a train of symptoms of its own. Tissues under a burned surface are apt to become inflamed, as the pleura, peritonæum, etc. Recently the close resemblance has been

pointed out between the shock and other sequelæ of burns and scalds, and profound toxæmia. Addakoff thought this an auto-intoxication, caused by the cessation of secretion by a large portion of the skin. Kijanitsin found in the blood of persons injured by burning a poison not present in normal bodies, and which, when injected into the lower animals, gave rise to all the constitutional symptoms of burns. Lustgarten thought this poison a ptomaine produced by the bacteria which had invaded the wound. Ayello and Parascandolo were able to show that this is not so. They took from any part of the body of a burned animal a poison so virulent that ten grammes injected into a dog weighing twenty pounds produced instant death. This poison was strongest when obtained from the burned flesh, and weakest from the blood. In the experiments of these two men, when the burned parts of animals were removed as soon as the burn was received, recovery without any of the symptoms usually following burning was invariable, while all died when amputation was delayed twenty-four hours, unless large quantities of blood were removed and healthy blood injected in its place.* These experiments explain what has always been more or less of a mystery: the internal lesions following burns and scalds.

In the treatment of burns the objects sought are, to save life, stop pain, and to produce, as nearly as possible, a smooth and non-contracting scar. In burns of moderate severity, and with a limited surface involved, the relief of pain first claims our attention. If blebs have formed, they should be opened at the base with a needle that has been heated in a flame. An infinite number of substances are used to allay the pain of burns and scalds, and almost every household has its pet remedy. They are mostly unirritating substances, used to keep out the air. Molasses, boiled starch, and the various unsalted fats and oils accomplish this purpose to a degree. Carron oil is still a favorite remedy and not a bad one, though it has many disadvantages. A saturated solution of ordinary baking soda, in water, as originally suggested by Dr. Hering, makes a bland lotion, and often gives great relief. Such substances as dry starch, flour, etc., cake on the surface, are irritating, and dam

* *N. Y. Medical Times*, vol. 26, p. 232.

back the discharges. The use of picric acid is so gratifying that within a few years it has found its way into almost universal use. It gives the best results in burns of the first and second classes, though it is a good dressing even in deep burns. In the original prescriptions a certain amount of alcohol was added to increase the solubility, but it has been found that alcohol also increases the absorption of the drug by the tissues, and some cases of poisoning from its use have been reported. The danger from poisoning from the local use of picric acid is very slight indeed, and is scarcely to be thought of when the great relief from pain is considered. Where facilities for dressing a burn are at hand, the injured surface should be cleansed with a mild antiseptic like boric acid or Thiersch's solution, then covered with gauze, and a gauze bandage applied. A saturated solution of picric acid should then be poured on the dressings, preferably with a large glass syringe. An ordinary muslin bandage should then be applied. This, as a rule, need not be touched for several days, when the dressings should be thoroughly soaked with a mild antiseptic solution and carefully removed. These picric acid dressings should be continued until there is no longer any pain when the injured skin is exposed to the air; then a dressing of aristol one part and petrolatum ten parts, as suggested by Dr. Cookman,* applied on gauze, will give excellent results.

The picric acid treatment for burns and scalds has but two great drawbacks: it stains the skin and clothing, and the removal of the dressings is both tedious and painful. Stains on linen are easily removed by boiling, but stains on the hands received when applying the dressing usually last several days, in spite of the vigorous application of boric acid, alcohol, ammonia, etc. In a burn of the scalp, nearly a year ago, I applied picric acid and dyed a fine head of blonde hair a number of shades of bright yellow. This artistic blending of yellows still persists, to be the cause of infinite questions, the answers to all of which include my name.

In our haste to get away from the greasy dressings of former days, it seems to me, as the Germans say, "We have thrown out the baby with the bath," the baby in this case being car-

* *Hahnemannian Monthly*, vol. 32, p. 144.

bolized petrolatum. The anæsthetic and antiseptic properties of picric acid are due to the carbolic acid, modified, of course, by the nitric. In carbolized petrolatum we have all the advantages of picric acid, and none of its disadvantages. It should be applied in a strength of 1-20, and should always be spread on gauze or strips of old muslin. It is not nearly so useful when applied to the wound with no dressing over it. No other fat or oil resists absorption as does this mineral fat, petrolatum; hence no other grease should be used. Even with petrolatum, the danger of carbolic acid poisoning should always be kept in mind and the urine watched carefully. I may say, however, that I have used this dressing extensively, and have yet to see the first case of poisoning from it. The same cannot be said of carbolic in such substances as olive oil and lanolin. Picric acid should never be used in the form of an ointment, over a large surface.

The relief of pain in superficial burns and scalds from the application of carbolized petrolatum is almost immediate. It has the property of excluding air, as well as all the anæsthetic properties of picric acid. It can be used, too, in burns of the face and hands, without disfiguring the patient for weeks after treatment is no longer necessary. When all pain has been subdued, the aristol treatment may be substituted with advantage.

Extensive and deep burns tax the skill and ingenuity of the surgeon to the utmost. First of all, shock must be combated. The patient must be kept warm. Cover well with blankets and pack around him hot-water bottles, hot bricks, or stove-lids wrapped in flannels, etc. Stimulants, whiskey, ammonia, strychnia, amyl nitrite, etc., should be cautiously given. When reaction sets in, etherize and cut away all burned flesh. The experiments of Ayello and Parascandolo show the necessity for this. The wound, too, must be made absolutely aseptic, or we have added the terrors of pyæmia. If, by the time reaction is well established, the patient shows symptoms of toxæmia, saline infusion should be thought of.

After sterilizing the burned surface, the question arises, "How shall the wound be dressed?" There is usually an area about a deep burn where a dressing of picric acid or carbolized petrolatum may be used to advantage. The deep wounds

should be treated as we would treat a skin graft: covered with green protective, then with gauze; or, after cleansing the wound and removing sloughs, the dressings may be applied over a support and not touching the wound. Benson, of London,* says that dressings applied directly to such wounds cause absorption of the lotion, causing general and local symptoms; the wet dressings cause flabby, unhealthy granulations; the discharges are retained in the wound; the vitality of the parts is lowered by contact with drugs, and the young cells are torn off when the dressings are removed. Reid, of Chelsea,† is enthusiastic over this method of dressing burns and other superficial wounds. He claims that dressings applied directly to the surface act as foreign bodies, and are to a great extent responsible for the mass of scar-tissue which usually follows these injuries. He uses a simple wire cage, made to suit each case, to hold the usual antiseptic dressings away from the wound. However the burn or scald be treated, cotton should never be placed in contact with the raw surface.

With reaction is apt to come inflammation of internal organs, and pleurisy, pneumonia, enteritis, peritonitis, nephritis and meningitis must be treated on general principles. Pain must be combated with full doses of morphia, for the pain alone is often enough to kill. One point I wish to make emphatic. With the intestinal lesions that often follow burns and scalds, a typhoid fever diet after an injury of this kind is more important than in typhoid fever.

When the wounds are covered with healthy granulations, Thiersch skin-grafts, either from the thigh of the patient or a donor, should be applied. This overcomes to a great extent the tendency to contraction. It is not necessary to wait for a smooth surface to apply these grafts, for hills come down and valleys fill up with surprising rapidity under the new skin. When the surface to be covered is not more than twenty-five or thirty square inches in extent, and the patient is not nervous, the skin-grafts may be taken from the thigh and applied to the wound without an anæsthetic, though, of course, the hands of an assistant must be the only retractors used. If the part from which the skin is taken be treated as a superficial burn, the pain is relieved almost instantly and healing is very rapid.

* *Lancet*, January, 1897.† *N. Y. Lancet*, July, 1898.

Masses of scar-tissue resulting from a burn and causing deformity should be thoroughly dissected away, and Thiersch grafts applied to prevent recurrence.

This, in brief, is the treatment of burns you will see followed in the Hahnemann Hospital and Dispensary. It seems to me that every homœopathic physician should spare space in his pocket-case for two drachms of picric acid. It will not do for all the burns he will meet, but it will relieve the pain in nine-tenths of them, though, where it is obtainable, I prefer carbolized petrolatum, 1-20.

TREMOR.

BY W. B. CARPENTER, M.D., COLUMBUS, OHIO.

(Read before Ohio State Homœopathic Medical Society, Springfield, Ohio, May 10, 1899.)

Not long since, while sitting in a hotel lobby conversing with a member of this Society, I was treated to an unusual neurological clinic. Within a very few minutes there passed us three patients, presenting three distinct diseases or disorders of the nervous system, the chief objective symptom in each being the trembling or tremor. Close attention to the coexisting symptoms readily showed the true ailment in each case. This circumstance in a public place made such an impression on me that I have frequently thought of that one symptom, "tremor," as an attendant, an important or a diagnostic symptom of disease. And to-day I feel as though it would be helpful to gather from experience and from testimony some thoughts and facts for our use as general or special practitioners.

Tremor is defined as an involuntary quaking or shaking caused by the alternate contraction and relaxation of opposing muscles, and consists in a more or less close succession of short vibratory or oscillatory movements. This definition removes the danger of confounding our condition with the spasmodic contractions in muscles or in muscular fibres, and the clonic contractions due to action of the deep reflexes on tendons. The *neuron* theory will explain these peculiar changes or effects better than any heretofore known; according to this, we know there is some alteration in the motor neurons in cortex and

spinal cord. In most diseases in which tremor is a symptom the exact seat of the lesion cannot be accurately stated, though the probability is that the cell body of the neuron is affected, while the axis cylinder shows only debilitation by carrying the nerve current feebly and irregularly. This probability is strengthened by the consideration that if the axis cylinders were so diseased as to destroy their conducting power a condition of flaccid paralysis would ensue, no matter what the physiological state of the nerve centres.

The study of this subject reveals the wonderfully great number of abnormal conditions which claim tremor as a symptom. "It may appear with any condition rendering patient more susceptible to irritation or the nerve centre action more imperfect." So we see the field is large and the list is long, from the simple tremor often seen in children and in whole families of "neuropathic" predisposition, through that caused by irritative or degenerative disease, or pressure, or excitement, or introduction of poison substances into the general system, to the tremor due to weakness following disease or due to the waning strength of old age. As regards tremor itself, many points of interest are noted, whether occurring during repose or during motion, or both; whether fine or coarse, whether regular in time and force or the opposite, whether general or special, whether controllable by patient or not, whether transient or permanent.

It is my purpose to give a hurried sketch of a number of the tremor cases without attempting an exact classification, a complete enumeration or a regular order. First, the three cases that furnished the text for this paper—two are associated with severe chronic diseases, and one the result of a poison.

(A). *Paralysis Agitans*.—Here the tremor usually begins in small groups of muscles of hands, fingers, arms, then legs—mainly in the flexors—then attacks muscles of head and neck and tongue. The movements may be fine, scarcely perceptible, and usually are in the first of the attack, becoming coarse (four or five to the second), even convulsive, as time goes on. All abnormal movement usually stops during sleep, but is not aggravated, in fact usually diminished, during voluntary effort, though mental excitement makes every symptom worse. Paralysis and muscular contractions are usually the last stages of the malady. Couple with the tremor, as noted, a position of

the hand as though grasping a pen, a tendency to run or fall forwards or backwards while walking, the body inclined forward, with a prominent 7'' cervical spine from carrying the head excessively forward, a passive, immovable expression of the face, embarrassed deglutition and speech, all this in a person from 40 to 60 years of age, and the picture will lead to an unerring diagnosis.

(B). *Multiple Sclerosis*.—A disease that may appear much earlier in life than the one last mentioned. Here the tremor only occurs when the motion is an intended one (not an *intentional* tremor, as stated in one of our late and prominent textbooks). This trembling is a coarse, slow one (three to five per second), and is one of the important motor symptoms that are pathognomonic of the disease. It is usual that the hand and arm show this peculiar trembling in the most marked way, but it may appear unequally on the two sides of the body, or in head and upper part of body as well as lower limbs. When there is a support to the trembling member or a rest from effort, the trembling ceases. Add to this symptom nystagmus, scanning speech, visual defects, pricking sensations in the affected parts, uncertain action of the sphincters, mental and psychic perversions, and the disease picture is complete.

(C). *Alcoholism*.—In any of its stages this deplorable condition is attended by a tremor usually in some or all of the extremities, in face and tongue. Severe muscular spasmodic contractions or twitchings may be present, and uncertain grasp, so that the patient easily drops things unless constantly on the watch. This trembling is associated with an awful restlessness, worse in the early morning, and disappears temporarily after a drink of whiskey. Post-mortem examinations have failed to show any lesions or changes of the nerve centres or nerve cords other than a hardening of the sheaths, the neurilemma. The rate of motion in these cases varies from 4 to 5 to 9 per second. Tremor here is an attendant symptom and not peculiarly diagnostic, yet it is important when associated with other marked and well known symptoms.

(D). *Mercury*.—Take now the tremor due to another toxic agent, "mercury." On account of the general use of this metal, the constitutional and poisonous effects are often seen. The history of the case easily determines the malady, and among the interesting developments the tremor and attendant nerve

symptoms are noticeable. Irritability of all the organs is seen, with an attendant prostration very similar to paralysis agitans. General tremor, as a rule, beginning in face, tongue and fingers, may be suppressed by volition, but generally increased by thought and effort. It presents such a strong analogy to hysterical intention tremor that Lutelle claims that mercury will only produce tremor in a highly neurotic predisposed individual.

There is a long list of the toxic tremors very similar in amplitude and regularity, and diagnosed by coexisting symptoms: *e.g.*, tobacco, chloral and opium, lead, uremia, coffee and tea; but I will now only refer to a tremor case in a tea-drinker.

(*E*). *Tea*.—A collegemate, a bookworm, for pleasure and for its supposed stimulant effect, became addicted to the use of tea in large quantities. During his work, and with no thought of the tea habit, an annoying tremor appeared at infrequent intervals, and then became more and more prominent and aggravating, noticed first in twitching and trembling of eyelids and eyeballs, in tongue, and in hand when making effort to write; the symptoms grew in force and extent till his work was sadly interfered with, and he was inclined to place himself in the list of physical wrecks, especially as he had for attending symptoms dull mentality, halos around light or objects looked at, irritable stomach, sallow complexion, hollow face, great lassitude, etc. Acting on the suggestion that an unusual amount of the beverage would mitigate all these symptoms for a time, a diagnosis of tea toxæmia was made, and antidotal corrective treatment sufficed in due time to redeem the patient.

(*F*). *Hysteria*.—In hysteria, tremor has only recently been admitted to the list of troubles of motility, but it seems to be a permanent symptom, appearing with the depression due to the long continuance of other stigmata. Charcot claims it is more common in men than in women, and may at times be seen in children. Tremor in hysteria is just as variable and irregular as are all the other symptoms. It not only differs in different persons, but is variable in the same individual, though in most cases it has the quality of persisting to some extent during rest. Is slow or fast (4 or 5 to 9 oscillations per second), intermittent or continuous, mild or intense, coarse or fine, located in one muscle, set of muscles, limb, side of body, or possibly in entire body, aggravated by continuous effort or even think-

ing of the condition, paralytic or not, acute or chronic; and parenthetically I may say there is a case on record where the trembling and other hysterical phenomena, but with no organic lesion, existed for more than twenty years, and was cured in less than twenty-four hours by the appropriate remedy. In its varieties of tremor hysteria may present similarities to paralysis agitans, sclerosis, ataxia, Graves' disease, senile tremor, or alcoholism—so much so that many observers claim that these various maladies present tremor among their manifestations because they are engrafted upon a so-called hysterical constitution. The so-called paroxysmal tremor seems to me to be properly classed under the hysterical variety by reason of its origin in sudden emotions or excitements or exertion, by varying rate and amplitude of the movements, by the fact there follows no loss of power in affected parts or in the reflexes.

(G).—Many other diseases have tremor associated with them in some form or other, and at some stage or other, either from mechanical reasons or asthenia due to exposure or heat or cold, excesses, exhaustion or loss of vital fluids. In this list we easily think of occupation, neurosis, epilepsy, brain tumor, hæmorrhage, apoplexy, non-cortical cerebral lesions and insanity.

(H). *Simple Tremor*.—The hysteria agitans of Sanders is a trouble coming with no ascertainable reason, appears in younger persons, even children, and often shows itself in families for many generations. The movements are of fine rapid oscillations, become worse by thoughts of effort, but do not prevent voluntary action. Bartlett presents statistics showing that this form is likely to be intractable to treatment, and lasts during life.

In this paper I have not followed any particular classification of the forms or types or peculiarities of tremor, as I do not think any satisfactory complete one has been made, and to attempt such a thing now, in time of such development and change in studies of the nervous system, would be fruitless.

As to treatment, I have nothing to offer as far as the special symptom under consideration is concerned. Not usually or ever an isolated condition, the *ensemble* presented by the patient must be the guide for treatment, including hygienic, sanitary, mechanical, suggestive and therapeutic measures, reinforced, maybe, by massage and electricity.

EDITORIAL.

WM. H. BIGLER, A.M., M.D.

WM. W. VAN BAUN, M.D.

COLLECTIVE INVESTIGATIONS.

IN endeavoring to build up and enlarge his knowledge on the basis of his experience the physician feels how limited, even under the most favorable circumstances, this individual experience is, and what a small proportion of all cases treated is made up of those which have fallen under his own observation. The finality of the results therefore must, to a conscientious physician, always remain more or less vitiated by the ever-recurring "personal equation," and hence collective investigation of disease has been undertaken with the hope of removing this personal element and arriving at a higher standpoint of observation.

Let us see whether this method, as at present carried out, is productive of the advantages hoped for. In the allopathic school, where the treatment in the majority of cases is directed against a diagnosed disease entity, there can be no doubt that the method is capable of enlarging almost indefinitely the experience of each physician. Given the name of the disease, the records of collective investigation will show him what remedies have been tried by his fellows, and in about what percentage of cases the experiments have been followed by favorable results. He has nothing to guide him in the selection of any particular line of treatment from amongst the many presented to him, unless it be the plausibility of the theory upon which it is based, or the larger number of reported successes that have attended its employment. He does not ask more, and is not disappointed in not finding any clearer indications. He is thankful, therefore, if some one draws attention to one or the other of the new remedies which are multiplying so rapidly around him, and gladly tries it in the same disease, relying upon its empirical use exploited by his colleague. For him the result of such collective investigation is of advantage, and helps to give variety to a method of practice which for many long

years before the discovery of the first coal-tar preparation had become very monotonous, as all old Systems of Practice amply show on every page.

But are such collective investigations of equal, or, indeed, of any benefit to the homœopath? Not many efforts have been made in our school in this direction. Providence sends us once a year, this time for the seventeenth time, with laudable regularity, the most persistent and conscientious effort. Has it done, does it do, or is it calculated to do any good? That its author hopes that an affirmative answer can be given to each of these questions is evident from the fact that the well-known series of questions continues to come with unfailing regularity. What is the good he sets before him to accomplish? He says "its sole object is to ascertain and to place upon record what is the exact practice of the profession relative to the condition or disorder under consideration." *Cui bono?* The simple knowledge of what is the exact practice of the profession in a given case might prove interesting if anything like exactitude were arrived at; but this is not the case. We, unfortunately, find the same variations in our own methods of treatment which we are so apt to condemn in practitioners of the other school. (In the paper on diphtheria we counted sixty different remedies that had been used; in pertussis, sixty-seven; in mumps, forty-six, each with varying degrees of frequency.) Even after the replies to the queries have passed through the hands of the indefatigable editor we have merely a percentage statement of the several items of treatment, from which the only deduction that can be made must be made by the reader of the report, and which is rarely to the credit of homœopathy. Of course the occasional reference to the "indicated remedy," and the earnest abjuration of all adjuvants, is encouraging, but the interest attaching to such a paper would be less likely to appeal to the friends than to the enemies of our system, were these latter sufficiently omnivorous in their tastes to concern themselves about our *Transactions*.

Is this method calculated to be of any benefit, any real benefit, to the homœopathic physician? We have seen that for one content to treat a disease according to its name, its copy-righted trade-mark, such records of various treatments can be of much service; but it is our pride and boast that such is

not our method; that we seek to treat the individual and his own peculiar symptoms, regardless of the name usually attached to the complex of such symptoms. What possible benefit can it be to us, therefore, in our selection of a remedy, to have a long list presented, in various percentages, without any indication other than a bare numerical preponderance to guide us? We grant that were we all as conscientious as we ought to be, we would seek by study to find the symptoms which led to the choice of some of the unusual remedies recorded; but, alas! too often we either make no further use of them, or are led by them away from our own known remedies to a shiftless empiricism.

This danger could be avoided if the answers to the queries as to remedies were expected to include, say, three characteristic symptoms which had led to the use of each. Such a demand, however, would lead in some cases, as we know, to a fearful prolixity, and in others to a no less fearful disclosure of the "nakedness of the land." It would be impracticable in a paper intended to occupy but a *part* of the published *Transactions*.

Are we, then, opposed to collective investigations? By no means; but we think we should have collective investigations not of diseases, but of remedies and their symptoms. Homœopathy is called upon at the present time to prove its truth by well-authenticated facts. We know that many of our readers will exclaim that there is no need of further proof, it has been given long ago, and that it is only the blindness and hardness of heart of its opponents which stand in the way of its universal recognition. Is this so? That it has proved its truth in very many instances is acknowledged even by its opponents, but the thing to be proved is that the law of similars is the *only* reliable guide in therapeutics, that it is of universal application in all curable cases; this can only be done by a constant accumulation of reliable facts in demonstration. We have been, and still are, too apt to explain the apparent failures of homœopathy much in the same way that the spiritualists, when brought to the point, gloss over their inability to substantiate their claims, "the conditions were not favorable;" we say "the totality of the symptoms was not obtained." It is in either case an explanation satisfactory only to believers; to others it is but a lame excuse.

We need to show that symptoms occurring in departures from health are invariably removed in all curable cases by remedies which produce similar symptoms upon the same pathological basis. The last qualification we consider absolutely essential. The underlying pathology may, indeed, be entirely unknown, but the more nearly the effects of the remedy coincide in their totality with the symptoms of the case the more confident we may be that the unknown cause in each case is the same. Why not, then, have collective investigations which shall serve to bring out these points? Let some remedies be proposed and our physicians be asked to state, not by lengthy quotations from the *materia medicas*, but in as few words as possible, those symptoms under each drug which are in their own practice characteristic guides in their selection, and in how far they prove reliable. Such reports, after passing through the hands of a painstaking and industrious editor, as Dr. Peck has proved himself in his own collective investigations, would be of the greatest interest and advantage to all homœopaths.

We are not unacquainted with the *Clinical Experiences* of Rueckert, the *Clinical Verifications*, as they appear in some journals, and the *Characteristic Materia Medicas* published, but these all differ somewhat from the line of investigation here suggested. In reading reports of cases cured by the single homœopathic remedy, where the symptoms leading to its choice are given, unfortunately but too rare, we are struck by the variations found, and often are unwillingly made to feel that the result of a happy chance shot has been justified in the report by an appeal to the *materia medica* and not to the case-book.

We merely throw out the above as suggestions for others to elaborate, if found worth it, only maintaining that collective investigations in the field of homœopathy must have a different object from that in the old school, and, therefore, must of necessity have a different form.

THE ATLANTIC CITY MEETING OF THE AMERICAN INSTITUTE OF HOMŒOPATHY.

THE fifty-fifth annual meeting of the American Institute of Homœopathy is an assured success. Atlantic City is the ideal

summer resort convention metropolis of the world, and the great steel pier, extending two thousand feet out into the ocean, will provide ample meeting-rooms for both general and sectional sessions, free from the annoying heat and noise of city auditoriums. The drowsy booming of the surf, the clatter of convention tongues and musical strains are all that remain to be overcome. The local committee will assume control of the latter two, while the former will be left to the masterful attention of the visitor.

The plan of meeting has been changed to a five-day session, without an intervening disintegrating Sunday, as of old. This arrangement will undoubtedly give strength and character to the scientific side of the Convention by inducing a large attendance of the most able men and women interested in the special scientific work of the sessions. Each Section will have one general meeting before the entire Institute, and provision has been made for all sectional meetings needed for the reading, discussion and elucidation of highly technical subjects.

The Local Committee, Dr. A. W. Baily, Chairman, with Dr. John R. Fleming, President of the Atlantic City Homœopathic Medical Club, have been unceasing in their efforts to promote the success of the meeting, and to provide for the comfort and social enjoyment of the visitors, and they have succeeded beyond all expectations. For a detailed account the reader is referred to the letters of Drs. Bailey, Baily, Porter and Garrison appearing in this month's *News* pages. Any one missing this meeting of the Institute will be unfortunate in many ways. The promise for the scientific work is exceptionally good, while the outlook for social diversion is unusually attractive, and comfort and goodfellowship will be unexcelled. A conservative estimate looks for over one thousand members and visitors.

RHUS TOX. IN RHEUMATISM.—Tearing, burning, or tensive pains, or pains as if sprained, with sensation of lameness and creeping in the affected parts; tearing pains, with sense of dull numbness after motion; paralytic pains in the joints; rigidity, or red and shining swelling of the joints, with stitches when touched; aggravation after midnight and morning, during rest and in bad weather. Suitable after *arnica* or *bryonia*.

GLEANINGS.

INDURATED CHANCER OF THE RIGHT SUPRAORBITAL REGION.—Dr. C. T. Hansen recently exhibited before the Danish Dermatological Society a male nurse of twenty years with an indurated chancre of the size of a “krone,” a quarter of a dollar, situated in the right eyebrow, an unusual site for a chancre. —*Hospitalstidende*, No. 7, 1899. (In the same issue of the same journal a correspondent relates an interesting case of a nursing child who had an ulcerated and long furrow on the dorsum of its tongue, with hard and raised edges; at the same time there were severe general specific symptoms. On investigation it developed that the mother had borrowed a nipple from a neighboring family of which the father admitted that he had syphilis. I once saw a young girl with a blooming chancre on her lower lip. In a neighboring town, at another time, I met with a case of chancre of the tip of the tongue in a young man who had had a pronounced submaxillary bubo. He was not at all proud of his acquisition. It has been asserted that the prognosis of extragenital chancres is less favorable than in the genital variety. However, no less an authority than Fournier denies this absolutely.)

MELANO-SARCOMA OF THE LIVER SECONDARY TO ONE OF THE CHOROID.—Dr. Zinn recently demonstrated before the Gesellschaft der Charité-Aerzte, of Berlin, a young woman of twenty-seven years, slightly icteric, with an unusually large tumor of the liver. Her abdomen was distended, striae visible in great numbers, the umbilicus smoothed out, and the greater portion of the abdominal cavity occupied by a tumor which extended from the right anterior superior iliac spine diagonally upwards to the margin of the left ribs, where, corresponding to the left mamillary line, a notch was palpable; thence it continued to fill the whole left hypochondrium. The tumor was consistent, smooth, hard, and the margin very sharp. This notch was probably formed by the interspace between the liver and the enlarged spleen. In her left eye, which was the key to the diagnosis, was a melano-sarcoma, springing from the choroid coat, from the ciliary body. The iris was partly torn off. Hence a diagnosis of a secondary melano-sarcoma of the liver from a primary melanotic-sarcoma in the eye was probable, and this was supported by the state of the urine, which, having stood several days, was completely black (melanuria). Only on standing a while does this characteristic color develop. Concentrated nitric acid, chloride of iron, chromic acid and tincture of iodine all colored this urine blackish. The prognosis was, as is well known, gloomy. On account of the vast size of the growth, no operative measures were indicated. This grave condition has developed during the course of a year. The number of red blood-corpuscles has decreased from 3.9 to 3.4, finally to 2.8, and now to 2.2 millions. Death may be expected in a short time. On account of the uniform consistence of the liver a diffuse sarcomatous infiltration of the organ was probable. Another form is nodular infiltration.—*Berliner Klinische Wochenschrift*, No. 10, 1899.

INJECTIONS OF OLIVE OIL INTO THE ŒSOPHAGUS TO FACILITATE INTRODUCTION OF THE STOMACH TUBE.—Dr. G. Kroenig, of Berlin, in those cases of poisoning with caustic substances where irrigation of the stomach is called for, yet where there is great danger of perforating the weakened walls, advises preliminary injection of olive oil through a small-sized soft-rubber catheter into the œsophagus, after which the irrigation tube will glide almost of itself into the stomach. The organ then should be washed out under very slight pressure, and from one-quarter to a third of a litre of fluid introduced at a time. This same method may be employed in sounding the œsophagus in cicatricial or cancerous stenoses.—*La Semaine Médicale*, No. 10, 1899.

ACUTE SUBGLOTTIC LARYNGITIS IN THE GRIPPE.—Dr. Paul Tissier states that in the grippe in children it is not rare to meet with cases complicated with acute subglottic laryngitis, while in adults it is a very rare condition. Such a laryngitis sets in with severe and serious symptoms. The child is completely voiceless, and soon great difficulty in breathing develops. On laryngoscopic examination the vocal cords are found but little altered, but below them a dark red prominence is noticed, often of such size that the laryngeal lumen is quite narrowed. The characteristic and sudden setting in of the stenosis appears to be due to vaso-motor influences. In adults there is a tendency to recur. Treatment consists of rest in bed and complete silence. To the throat, warm and frequently repeated applications as well as inhalation of steam are recommended. In grave cases a tracheotomy may be necessary.—*Deutsche Medicinische Wochenschrift*, No. 6, 1899.

TWO CASES OF APHASIA WITH HEMIPLEGIA APPEARING IMMEDIATELY BEFORE LABOR.—Prof. F. Jolly records two cases of women of twenty-eight years, both of whom, on the day immediately preceding normal labor, which was wholly unassisted instrumentally, and without any preceding apoplectic stroke, were affected by right-sided hemiplegia and aphasia. No predisposing causes were discoverable. In the second case there was an apparent nervous predisposition and chorea during youth, and during the pregnancy twice attacks, once of transient unconsciousness without spasms, and another of paraphasia of several days' duration, which was attributed to a disturbance of circulation in the brain. Probably in this case there was a focus of softening from circulatory weakness, and finally arterio-sclerosis. Jolly touches upon the diagnostic difficulties in cases where the influence of pregnancy complicates already existing cardiac valvular insufficiencies and organic cerebral disease, and finally communicates a case where hemiplegic symptoms were the introductory signs during pregnancy of a dementia paralytica.—*Deutsche Medicinische Wochenschrift*, No. 6, 1899.

FRANK H. PRITCHARD, M.D.

A NOTE ON THE SUPRARENAL CAPSULE.—In case of chronic otorrhœa, Thompson finds that where, after washing out the canal, the fundus appears filled with granulations, the membrane swollen, and the tympanic cavity occluded by a red and thickened mucosa, the external canal is filled with five grains of the pulverized desiccated suprarenal capsule of the sheep, dissolved in two drachms of water, the granulations will disappear at once, the swelling of the mucosa diminish, and the hole in the membrane and the cavity of the middle ear become opened up.—J. H. THOMPSON, Kansas City, *Med. Record*, vol. xvi., February, 1899.

WM. SPENCER, M.D.

LA GRIPPE.—J. C. Kilgour, M.D., Harrison, Ohio, says: "I have sometimes been able to abort the disease when I saw it in its first onset by spraying the nares with a two per cent. solution of carbolic acid, and even using a five per cent. solution in aggravated cases. Therefore I have thought that, as the hypodermic treatment with antitoxin, which contains a certain percentage of carbolic acid, has done so much for diphtheria, why not also attack the germ of la grippe in a like manner? but leave out the serum and use only the acid in the strength of one-tenth of one per cent. in distilled water, for I am more than half inclined to believe that the carbolic acid alone is the curative element in the antitoxin, and the unpleasant sequelæ that sometimes appear after its use are due to the other ingredient.

Now if some of our brethren having hospital opportunities will test this theory and give us the result, they may possibly confer a great boon on suffering humanity. By taking the first centesimal dilution of the *Homœopathic Pharmacist* and diluting one part of this with nine parts of distilled water we will have it in the strength of one-tenth of one per cent., and suitable for hypodermic use.—*Eclectic Medical Journal*, March, 1899.

CARBOLIC ACID POISONING.—Dr. Stephen Hornesberger, Catlett, Va., reports a case of above poisoning, with recovery. The principal remedy used was cream, administered at frequent intervals for about eighteen hours. Actuated by his experience in such cases, he was led to try a few experiments on the human subject with carbolic acid extinguished with glycerin and cream, or with alcohol, glycerin and cream. From the results obtained, he is of the opinion that as much as four drachms of carbolic acid can be administered in this manner to an adult without risk of symptoms of its toxic effects—and in certain cases even larger doses. Under two-drachm doses, neither objective nor subjective symptoms were observed. Three-drachm doses caused only a slightly warm sensation in the mouth and throat, but no gastric uneasiness. No effect was noted upon the pupils, pulse, respiration, temperature or kidneys. The following case by Dr. John Sweaney, of Leaks-ville, N. C., was also reported:

Child, age 24 months.—Supposed to have swallowed two drachms of carbolic acid. Gave one teaspoonful of magnesium sulphate in solution, followed by glycerin. Also egg and sweet milk. For the shock, nitro-glycerin and strychnine. Child made an uninterrupted and perfect recovery. If given at once, the sulphate of magnesia unites with the carbolic acid and forms the sulpho-carbolate of magnesia. This is the only known chemical antidote, and probably not very well known to the profession.—*Charlotte Medical Journal*, February, 1899.

THE TOXICITY OF TOBACCO AND A METHOD OF ERADICATING IT.—Dr. Heinrich Stern, Ph.D., M.D., New York, describes a process for the treatment of tobacco leaves, preventing the injurious action of nicotine and acrid fumes of the plant. This process he accredits to Dr. Gerold, of Halle. He employs for eight kilogrammes of tobacco leaves, containing the average percentage of nicotine, a decoction which is prepared thus: "Fifteen grammes of tannic acid are boiled with one and one-half kilogrammes of water until the weight is reduced to one kilogramme; then thirty grammes of the essential oil of *origanum vulgare* are added, after which the decoction is immediately removed from the fire. Having stood for some minutes the mixture is filtered

and allowed to cool to about 16° C., when the preparation is ready to spread over the previously weighed tobacco. When the absorption of this mixture by the tobacco leaves is completed they are subjected to slight pressure and moderate heat, after which they are ready for the manufacturer." Dr. Stern has had cigars made from tobacco prepared in this way and has given them to patients who were markedly idiosyncratic against tobacco. Each patient had to smoke three cigars in succession, and he failed to detect any functional alteration, which would occur in these individuals after taking a few puffs only from a cigar; the nervous system seemed to be not affected, hemicrania was absent, which was not the case when ordinary tobacco was employed.

He ascribes this non-toxic effect to the neutralizing effect of the tannic acid upon the nicotine and the action of the oil of origanum upon the empyreumatic substances, rendering them totally or at least relatively innocuous.—*Medical Review of Reviews*, April, 1899.

SIMPLIFIED METHODS OF BLOOD EXAMINATION.—Alfred C. Croftan, M.D., Pasadena, Cal., says: "A good microscope, a few cover slips and slides, a bottle of Ehrlich stain, on the one hand, a general knowledge of the morphology of the normal blood corpuscles and a memorized appreciation of the changes they present in different diseases, on the other hand, constitute our working material.

"Information sufficiently accurate for diagnosis can be obtained in this direction from a single glance at the colored blood-slide. The same, though not quite so radically, may be said of the determination of the hæmoglobin; the percentile measurement of this constituent of the blood is a simple procedure with the aid of Gower's or Fleischl's apparatus; but it is not necessary, and in my experience, again, a careful and appreciative study of the blood-slide will give information that suffices for diagnostic purposes.

"Under ordinary aseptic precautions the ear-lobule of the patient is pricked with a clean-needle, the droplet of blood that oozes out (no pressure should be exerted) is spread in a thin layer between two cover slips and allowed to dry in the air; in order to fix the blood on the slide and to prevent its being washed off in the subsequent manipulations, the slips are wrapped in paper and placed into a little copper box (usually called a blood oven) and heated to 110° C.—or they can be placed in a mixture of equal parts of alcohol and ether for twenty-four hours. A few drops of Ehrlich's triple stain are placed upon the cover slip and allowed to remain for about two minutes, then washed off with water, the slips dried between filter paper and mounted on a slide with a drop of Canada balsam. The slide is now ready for examination.

"There are three kinds of corpuscles in the blood, the red (erthrocyte), the white (leucocyte), and the blood-plaque. The latter plays no rôle in diagnosis, so we describe the former two alone.

"The normal red-blood corpuscles present themselves as round discoid elements with a central depression. They are arranged in rolls, have no nucleus, are uniform in size and shape, and their hæmoglobin (with Ehrlich stain) is colored reddish-yellow, and forms a concentric ring around the central depression. Pathologically, five abnormalities must be observed: 1, they can be reduced in number; 2, they may have a nucleus; 3, they may present differences in size; 4, they may present differences in shape; 5, the hæmoglobin of the individual cell may be reduced. All these abnormalities can be deter-

mined by a glance at the blood-slide; reduction in number by the fact that the blood-corpuscles are not, or only in part, arranged in rolls, and appear as individuals; the presence of nucleus by the appearance of a blue circumscribed body within the cell; changes in size and shape are apparent, and the reduction of the hæmoglobin may be determined sufficiently accurately for diagnostic purposes by a narrowing of the concentric red ring described above.

"The characteristic features of the normal white cell or leucocyte are that it is larger than the red-blood corpuscle, has one or several nuclei, and a protoplasmatic content which may be homogeneous or have fine or coarse granulations. The nuclei are stained blue, the homogeneous protoplasm pink, the fine granulations violet, and the coarse ones bright red. A leucocyte with the bright red coarse granulations is called 'an eosinophile cell.'

"The abnormalities observed are chiefly numerical, *i.e.*, an increase relatively of all or a part of the different kinds of leucocytes. An increase of leucocytes is called 'a leucocytosis;' if the leucocytes with several nuclei are increased, we speak of a 'polynuclear leucocytosis.' A simple method of determining whether a leucocytosis exists—one that does away with the tedious counting and is all-sufficient for diagnostic purposes—is the following: Normally, one leucocyte should be found on an average in every fifth field; when we find two or three in every five fields we speak of a slight leucocytosis, while one leucocyte to every field and more constitutes a severe leucocytosis. Many observations have been chronicled on the different forms of leucocytosis, but their diagnostic significance is doubtful. It is, for the present, sufficient to verify that an increase of leucocytes obtains; especial attention should be given to the absence, presence or increase of the above mentioned eosinophile cells."—*Medical Times*, N. Y., May, 1899.

A LOCAL APPLICATION IN DIPHTHERIA.—Dr. H. L. Henderson, Astoria, Oregon, gives the following formula for the above disease: Take of sulphur, one part; unslacked lime, two parts; water, twenty parts. Slack the lime to a paste (not using any of the twenty parts of water, add the twenty parts of water, and heat to boiling. When boiling, add the sulphur with constant stirring, and evaporate to twelve parts, stirring continually while evaporating. Filter while hot. The product is a clear amber-colored solution, strongly alkaline, with a sweetish taste and strongly sulphurous odor, permanent while securely corked.

He uses the solution as an application in diphtheria, full strength in the case where he is using a swab or probang, and in the case where he thinks the disease is mild, and if an atomizer is employed, he sometimes dilutes with lime water. It should be applied every two or three hours in the case of ordinary severity. It is non-irritating to the unaffected mucous membrane and is non-poisonous when swallowed.

He has never had a case of diphtheria in which the membrane has extended to new areas after he had begun the application of this solution.—*Electric Medical Journal*, May, 1899.

W. D. CARTER, M.D.

SOME ESSENTIALS IN SUCCESSFUL APPENDICITIS WORK.—In the *American Journal of Surgery and Gynecology* for April, Dr. Robert T. Morris, of New York, presents a most able article under the above caption. He says:

"Skillful palpation gives us the best single resource for close information (as to diagnosis). Do not postpone operation in the belief that the case is a

mild one and disappearing. Perforation may occur at any moment. Portal embolism may surprise you. The patient may not be under your care when the next attack appears. Do not postpone operation in the hope that the patient will not have another attack. About twenty per cent. of appendicitis cases have hard or soft concretions in the appendix; more than eighty per cent. have a mucus inclusion after one attack has subsided. Do not trust reports of series of cases treated by medical means. The mortality rate of twenty-five per cent. in appendicitis treated medically must be constantly compared with the mortality rate of a fraction of one per cent. in those cases treated surgically in a proper way at the proper time. Do not think appendicitis surgery is easy surgery. Many cases thought to be good cases for successful operation suddenly hold the surgeon close up to the last points in his most skillful technique, and the patient is lost unless the surgeon has at his fingers' ends the resources of long training. A pair of scissors, knife, artery forceps, a single hook-retractor, and needles—these, and no more, are the instruments that are used regularly for the best appendicitis work in the simplest and in the most complicated cases. Do not depend upon the sense of sight in operating upon appendicitis cases that are advanced to the stage of adhesions, of pus, of septic peritonitis. The sense of touch enables us instantly to recognize structures and to work rapidly. Avoid protracted operations. The most complicated cases seldom require more than thirty minutes of operative work.

“Do not use gauze packing. Its presence prolongs the condition of shock. It causes excessive exudation of lymph. It sometimes causes mechanical obstruction of the bowel. A tiny gauze wick drain surrounded by gutta-percha tissue that will not adhere to the peritoneum, and that will allow nice suturing of structures, is the proper thing to use in the few cases requiring drainage. Above all things, avoid iodoform gauze packing. Iodoform poisoning is usually called ‘septicemia’ or ‘exhaustion.’ In these conditions pour a few drops of the patient’s urine upon a pinch of calomel and stir with a splinter of wood. Note the yellow reaction, showing the presence of iodine. Avoid the use of strips of gauze distributed in various directions for drainage. Trust a small gutta-percha-covered wick-drain to do all the necessary drainage. Do not fail to remove the appendix, unless the patient’s condition is desperate. Destroy pus, as fast as it appears, with hydrogen dioxide, and wash away the debris with normal salt solution. Depend upon high rectal enemata of Epsom salts to relieve symptoms of sepsis after operation. Stretch the sphincter ani, or introduce a gas tube, or do both, in order to allow free escape of gas from the bowel after operation. The expulsive effort is distressing otherwise. Avoid the use of opium before and after appendicitis operations.

“Do not classify appendix surgery as *cheap surgery*. It is a disease which may bring us very close to life-and-death questions, and the responsibilities may be enormous. The surgeon who is to do this work should so perfect himself that his work is worth thousands of dollars in simple cases. There are a great many surgeons whose appendicitis work is not on a par with their other surgery. The surgeon whose reward has been a great clientele must of necessity fail for lack of time to develop some lines of surgery in which he fain would become proficient.”

TUBERCULOSIS OF THE CÆCUM.—At the Surgical Congress, M. Tedenat, of Montpellier, reported observation of the above, the tumor resembling cancer. Symptoms were those of dyspepsia and constipation, general health good, occasional appearance of slight appendicitis. An ileo-colic resection of the tumor was made. M. Jonesco observed three cases of this kind; made ileo-colic anastomosis without touching the tumor, which finally disappeared. —*French letter to New York Medical Times*, May, 1899.

A year ago a case of this kind was fed to Dr. Van Lennep's Saturday clinic. The cæcum, several inches of the colon and two inches of the ileum were resected, and at a second operation an ileo-colic anastomosis attempted. The patient made an uneventful recovery, but a fecal fistula remained, which to this day has refused to heal. Two cases of tuberculous appendicitis that I now think of have left persistent fistula, though in both cases the appendix was removed and the opening into the cæcum closed. Tuberculous lesions of the appendix are not at all infrequent, as the post mortem table shows. In fact, tubercles are usually found in the appendix when they are present in the ileum. This naturally brings up the question of the rôle played by tuberculosis in fecal fistula following appendicitis operations.

A CRITICISM OF WHITEHEAD'S OPERATION FOR PILES.—In the *Virginia Medical Semi-Monthly* for April 14 Dr. S. G. Gant gives his objections to Whitehead's operation and its various modifications, and sums up his criticisms as follows:

It is difficult and bloody.

Patients are detained in bed from six to fifteen days longer than after the clamp and cautery or ligature operation.

Owing to tension the post-operative pains are severe, and may continue for several days.

Infection is frequent, and terminates in a stitch or deep abscess and fistula.

Because of non-union, ulceration, stricture and pruritis are common sequelæ.

The portion of bowel between the anus and the end of the retracted intestine loses its sensitiveness, and there is also an absence of the normal secretion.

The nervous and mental state of these sufferers is pitiable to behold, and many contract the morphine habit, while others turn up as chronic invalids in some sanitarium or asylum.

In a letter to the same journal published on the 28th of April, Dr. Thomas H. Manley, of New York, criticises the critic and gives "An unqualified condemnation of Whitehead's operation *as it is often performed*. The originator of this operation is not so much responsible for the lamentable results as the unskillful performance of it.

Nevertheless Dr. Gant has condensed the nebulous opinions of the rectal surgeons outside of Chicago, and there are hopes that the visions of the diaper brigade and numerous suits for malpractice will lead to its abandonment in that stronghold.

F. WALTER BRIERLY, M.D.

INVESTIGATIONS ON INFECTION OF PUERPERAL WOUNDS (Pourtalès).—There should be a distinction between primary septic phlebitis and the secondary infection of a thrombus already formed and partly organized.

In the first case the streptococci spread out from the placental site, as a

primary focus, over on the endothelial lining of the veins where the blood current is slowed, necrosis of the endothelium follows, and then the formation of a thrombus follows.

In secondary infection of a thrombus, the streptococci extend along the centre of the blood coagula which fill the veins at the placental site, and extend out to the plexus of the broad ligaments in many lying-in women.

Special emphasis should be placed on the fact that germs of putrefaction are found in broken-down thrombi as well as the streptococci. The presence of purulent metastatic abscesses has been long established by clinical observation. The proof of the presence of the bacteria of putrefaction in the thrombi of the genitals proves that such bacteria come by way of the blood current.

It is interesting to know that there may be an exceedingly abundant growth of bacteria in the broad ligament—*i.e.*, a beginning stage of parametritis.

The bacteria may penetrate the thin wall of a distended tube and infect the peritoneum by direct extension out on the serous membrane.

An infected thrombus in the crural vein containing colonies of streptococci may cause a general septicæmia.—*Archiv für Gynæcologie*, Bd. 57, H. 1, 1898.

A NEW METHOD FOR THE TREATMENT OF INFLAMMATORY AFFECTIONS OF THE PELVIS (Ludwig Pincus).—At the close of an elaborate essay and review of the literature Pincus summarizes as follows:

1. The treatment in private practice of inflammatory, and especially exudative, processes about the uterus and its appendages—*i.e.*, in the parametrium as well as in the pelvic serosa and in the tubes—must be, in the first place, non-operative. The operation is a last resort, and, whenever possible, must be conservative and preservative of function. Disability is often an indication for operation in clinical and dispensary practice.

2. The most important requisite of a rational therapy, both in the acute, subacute and chronic stages of the affections named, is to disencumber the pelvic organs, in a surgical sense, as completely as practicable,

(a) By raising the abdominal blood pressure;

(b) By promoting the return flow of the venous current;

(c) By consecutive quickening of the lymph stream by gravitation;

(d) By elevation of the pelvic organs, raising them out of the small pelvis, or elevation of organs pressing down.

(e) By absolute rest of diseased organs and their surroundings.

3. These theoretical requirements for obtaining rapid absorption and energetic elimination of the cause of infection is met in practice by resting in an inclined plane with compression, which characterizes the treatment.

4. This leads to an autotransfusion to the medulla oblongata and to the heart, and acts as a stimulant for the circulation.

Methodical respiratory gymnastics expand the capacity of the thorax and act as a means for the maximal development of the suction of the respiration.

It is very important to watch over nutrition in the sense of Mitchell's cure, to preserve the strength of the body in general, and of the fat cushions of the pelvis in particular.

5. The inclined plane is obtained by raising the foot of the bed fifteen centimeters as the minimum or thirty-five centimeters as the maximum—*i.e.*, an angle with the horizon of about 12–30°. A higher inclination may be used

rarely, and always only temporarily. In the treatment of recent puerperal affections the inclined plane may be a piece of drilling or sail cloth in a frame which can be raised or lowered, as desired.

6. The position on an inclined plane is permanent, except in recent puerperal affections, on account of the lochia and the necessary vaginal injections, which make an intermitting position necessary.

Compression is partly by the use of direct pressure and partly by the law of gravity acting on the pelvic and abdominal organs.

8. Direct pressure may be applied on the abdomen, in the vagina, or in both ways, which is better. Vaginal compression assumes the character of active pressure only in very marked chronic cases, and is balanced by some resistance introduced to maintain the organ in a position of rest.

Compression from without is obtained by elastic binders, surgical plaster, a shot bag, or moist potter's clay, weight, 1-5 kilos. Vaginal compression is exerted by Gariel's air pessary, the Kolpeurynter, shot bag, and columning the vagina with sterile dry material.

9. Compression is intermittent or permanent. Duration and intensity differs for the individual. It is allowable in the acute stage only with the use of the inclined plane at the same time, and fever and pain is diminished by it, though it may be temporary. Compression may be permanent in the chronic stage if the patient remains free from pain and fever, and it must be intermittent if pain and fever occur. Gynæcological massage in chronic cases is often beneficial.

10. The inclined plane and the typical methods of compression are adapted to the treatment of all forms of abdominal plethora, and especially to all affections of the generative organs associated with hyperæmia, for the loosening of adhesions, and to improve the position of the uterus or ovaries. Its peculiar domain is the treatment of extensive chronic exudates in the pelvis (pelvic cellulitis, pelvic peritonitis, and tubal affections). Acute inflammations are often benefited to a marked degree, though often only in an intermitting form. It is contraindicated by peritoneal inflammation. The duration of treatment varies from several days to as many months. The character of the complaint determines the prognosis.

The treatment of chronic disease must allow the patient to walk about whenever possible. It is given by vaginal compression and an elastic abdominal belt. The inclined plane is used for a few hours daily, and in the night permanently.

11. If, in spite of this treatment, the exudate does not diminish, as may occur in puerperal peri- and parametritis, and there is fever and loss of strength, there is not only pus in the exudate, but there may be a perforation which requires an exploratory incision.—*Zeitschrift für Geburtshülfe und Gynäkologie*, Bd. xxxix., H. 1., 1898.

MYOMECTOMY BY A NEW METHOD (Skene).—The method consists essentially in crushing with hæmostatic forceps the tissues to be divided and drying with electric heat hot enough to dry the tissues, but not to char them, thus doing away with all ligatures. General oozing is arrested by a long-handled hæmostatic forceps for the large vessels and the hæmostatic dome to dry the tissues.—*Am. Gyn. and Obstet. Journ.*, March, 1899.

THE VOMITING OF PREGNANCY (Klein).—The writer agrees with Kattenbach and Frank that the term hyperemesis gravidarum should be limited to those cases where the vomiting is caused by pregnancy, and when the nutrition of the patient suffers in consequence. The cause of hyperemesis in a more restricted sense may depend on a neurosis or hysteria. The cure of hyperemesis of the first and second degree is accomplished by liquid diet and rest to brain and body. If home treatment is not beneficial in a few days the patient should be taken to a hospital. Early treatment is of the utmost importance. Both local, medicinal and suggestive treatment may be employed. The interruption of pregnancy is sometimes necessary.—*Ibid.*

GEORGE R. SOUTHWICK, M. D.

INTERSTITIAL ELECTROLYSIS WITH COPPER ELECTRODES IN OZENA.—The conclusions of the authors are quite encouraging. Interstitial electrolysis with copper electrodes has a certain usefulness on ozena and its manifestations. The bad odor disappears.

How it acts it is difficult to say. The formation of oxychloride of copper and its influence are doubtful.

The good results seem to persist for a long time, yet it cannot be said that they were permanent. Accidents are rare with a good technique. The dangers have been exaggerated. (Gougenheim et Lombard).—*Annals des Malad. de l'Oreille Larynx du Nez et du Phar.*, No. 11, November, 1898.

THE DIAGNOSTIC CHARACTERISTICS OF HEADACHES ACCORDING TO THEIR ORIGIN.—Among nasal diseases, the forms more likely to lead to persistent and unusually severe headaches are the more intense suppurative inflammations of the sinuses, in which cases nasal symptoms can always be elicited. Nocturnal aggravations are not uncommon under these circumstances. Moderate but very persistent headache is occasionally complained of in nasal stenosis of any kind, but only by distinctly neurotic subjects. It is less generally known that inflammatory conditions of the pharyngeal tonsil are sometimes the source of continuous headache, usually not very severe, in both children and adults. (H. Gradle).—*Jour. of American Med. Asso.*, Nov., 1898.

DIPHThERIA — ANTITOXIN HOMŒOPATHICALLY CONSIDERED.—After giving several extracts from reports of the physicians in charge of some of the larger hospitals in Germany and France which treat large numbers of this disease, some of which favor and others discountenance its promiscuous use, one enumerates the following as the bad effects of serum treatment: "Serum eruption in connection with rheumatism, cervical adenitis, epididymitis, inclination to hæmorrhage, albuminuria, localized œdema and severe affections of the kidneys." After this very thorough consideration the author believes that there are certain forms or cases of diphtheria in which antitoxin is the indicated remedy, the same as any other of our old-tried friends, merc., cyan., apis, etc. "The useful sphere of this remedy is in the beginning of the uncomplicated Klebs-Loeffler diphtheria, free from all admixture of other forms of bacteria where the exudate is abundant from the start, and especially where tendency prevails for the invasion of the respiratory organs." These are the so-called "diphtheritic croup," with "a suspicious barking cough or a fine sawing respiration"—"here antitoxin seems to come in with ready specific effect;" but it must be administered without delay. (Martin Deschere).—*North Am. Jour. Hom.*, November, 1898. WILLIAM SPENCER, M.D.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND
THERAPEUTICS.

THE TREATMENT OF MALIGNANT DISEASE OF THE UTERINE BODY.—Barford, of London, lays down the following canons of treatment :

1. The sphere of therapeutics is (*a*) where the malignant disease has overflowed the confines of the uterus; (*b*) where metastasis to other organs has occurred; (*c*) where concomitant conditions (age, organic disease) preclude operative interference.

2. The sphere of surgery is the early stage of uterine malignant disease and before metastasis or overflow has occurred. The early stage is eminently favorable for successful radical treatment.

3. Neither pronounced local symptoms nor marked cachexia are in themselves any bar to a successful issue. This is determined by a clear circumscription of the disease by the uterine tissue. The implication of glands is often quite late in the history of the disease.

4. Those forms of malignant disease whose clinical course is most rapid before operation (sarcoma, deciduoma malignum) are the most liable to recur after operation. For malignant tumors of some size, with a recent history of rapid growth, and especially if adhesions can be demonstrated, radical operation is undesirable, early recurrence is almost certain, and the growth is even more rapid than before. Therapeutic measures alone are here applicable.

5. Those forms of malignant disease of the uterine body whose clinical course is relatively slow (carcinoma, malignant adenoma) are least liable to recur after operation. *Every case of carcinoma or malignant adenoma of the uterine body is salvable as long as the uterine lesion is definitely self contained,* and the remedy is immediate total hysterectomy. Delays are dangerous.

6. For the relief of the hæmorrhage and fœtid discharge in the earlier stages of inoperable cases, as well as the control of the sapræmia from absorption, local measures are very effective. These include both the local douching with deodorants so absolutely requisite, the application of local remedies such as hydrastis or arsenic, and the removal of the fœtid and necrosed *debris* by the curette. The use of internal remedial measures is also of great value.

7. For the relief of the symptoms in the late stages of malignant uterine disease, the higher dilutions, carefully prescribed, are often of more service than the lower potencies.

8. As regards operative removal, carcinoma and malignant adenoma of the corpus uteri are on a totally different plane to that of malignant disease elsewhere, even in the cervix. Its results, as regards absence of recurrence, are far and away before those of operation for cancer in the breast, or intestine, or tongue.

All recent work points to the conclusion that *practically every case of malignant adenoma or carcinoma of the corpus uteri would be permanently salvable if taken sufficiently early* and operated on with sufficient care. Once past the line of demarcation, and the circle of the patient's life rapidly narrows.—*Monthly Hom. Review*, May 1, 1899.

THE THERAPEUTICS OF PERITONITIS.—Burford and Johnstone, of the London Homœopathic Hospital, present a scholarly and scientific study of the *Modern Aspects of Peritonitis, Medical and Surgical*, and conclude that the dividing line which separates septic from inflammatory in clinical type, in pathology, in symptomatology and in prognosis, sweeps through treatment also. Having determined that, in a given case, the symptoms are septic, the internal therapeutics include *crotalus*, *lachesis* and *rhus*. These are addressed to the elimination of the septic symptoms. It is perfectly useless—the error has cost many a valuable life—it is quite useless to approach a case of septic peritonitis with the remedies that are specially adapted for states where inflammation is paramount. It is the septic element in these cases that kills. It kills by heart failure, the septic intoxication affecting the whole sympathetic system, but having its chief incidence on the vasomotor ganglia. The serpent poisons are specifically homœopathic to this septic poisoning, *crotalus* and *lachesis* in particular, and the writers' firm belief is that the success of these remedies is bound up with their administration in low potencies, and preferably by hypodermic injection.

The ordinary heart-muscle tonics—arsenic, *strophanthus* and *digitalis*—appear to be quite useless in contending with the powerful depressant action of these bacterial toxins on the cardiac ganglia. Anti-streptococci serum has been reported of service in some cases of septic poisoning of puerperal origin. Alcohol, purgation, external applications and washing out of the stomach are unsatisfactory measures. Surgical measures have in some cases proved of paramount value.

When, however, the symptoms are mainly inflammatory, in the very forefront of efficacious measures comes the use of *belladonna*, *mercurius cor.*, *bryonia*, *colocynth*, *terebinthina* and *veratrum viride*. These remedies, selected according to the special indications of the case, will admirably control, in most instances, the inflammatory process as affecting the peritonæum. Few things in medical practice are more satisfactory than to watch the subsidence of the acute stage and the neutralization of the stress of the attack under the action of such of these remedies as are germane to the symptom. The bowels should be opened only by means of enemata, while the application to the abdomen of a glycerole of belladonna and the use of the ice bag are to be commended.—*Journal of the Brit. Hom. Society*, April, 1899.

REMEDIES FOR DIARRHŒA IN CHILDREN.—Dr. J. Roberson Day, Physician for Diseases of Children to the London Homœopathic Hospital, gives the following list of the remedies which he has found most useful in the diarrhœas of children :

Mercurius sol. or *corrosivus* 3x is, perhaps, the medicine which he uses most often, the *green* motions being the indication, and, when mixed with slimy mucus and blood, the *corrosivus* is specific.

Ipecac. 1x, where vomiting and diarrhœa coexist, and especially if cough and bronchitis are present.

Arsenicum alb. 3x for profuse watery diarrhœa, especially in the morning, with thirst and restlessness.

Colocynthis 3, where there is much griping.

Croton 3x and 3, for sudden expulsion of fæces and tenesmus.

Podophyllum 3, when associated with prolapsus ani. If the prolapsus ani is of recent origin, with an acute attack of diarrhœa, podophyllum is specific; but if the prolapse is of long standing, associated with chronic diarrhœa, its effects are disappointing, and other remedies will be needed, like aloes or china. It is most important to improve the general state of nutrition in these cases, and the prolapsed bowel should be promptly returned, using as a lubricant hamamelis ointment.

Aloes 3x, where there is much tenesmus, the lower part of the bowel being the chief seat.

Rheum 3x, for the very sour-smelling motions.

Calcareæ carb. 6, for diarrhœa in rickety children, than which there is no finer medicine.

Chamomilla 8x, when associated with teething and great restlessness and fretfulness.

Ars. iod., 3 and 3x, for very fœtid motions in tubercular subjects.

China 1x, where there is great debility. Often it follows well one of the foregoing.

Acid phosph. 1x, used in the same way, especially in neurotic subjects passing phosphates in the urine.

In addition, alcohol is necessary in many cases in doses of from 3 to 15 drops, according to the age of the patient. Lavage of the intestines and of the stomach may be employed. General hygienic and dietetic measures are, of course, essential.—*Journal of the Brit. Hom. Society*, April, 1899.

A FRAUDULENT MEDICINE.—Some months ago a Texas medical journal published an account of *husa*, a singular plant found in Florida, and alleged to be an antidote for snake poison and a cure for the opium habit. This statement was copied into many journals and attracted considerable attention. Under the circumstances it became desirable that an exact botanic description of the plant be obtained, but Prof. John Uri Lloyd, of Cincinnati, found to his surprise that Dr. Winthrop, its discoverer, refused to send specimens of the plant, and supplied only a tincture arranged in ten vials, graded according to strength and representing one month's treatment. The printed directions stated: "Husa is not a narcotic." Analysis, however, disclosed the presence of morphine, salicylic acid, alcohol, glycerin and water, with coloring matter. It is probable that the perpetrator of this fraud has reaped a rich harvest, thanks to the numerous notices given the "new remedy."

ARSENIC IN HEART DISEASE.—Balfour, of Edinburgh, in his book on "The Senile Heart," says of arsenic:

"Most excellent results, indeed, occasionally follow the prolonged use of almost infinitesimal doses. I well remember one old gentleman, exceedingly sensitive to the action of drugs, to whom the $\frac{1}{50}$ grain of arsenious acid was quite poisonous, but who could tolerate the $\frac{1}{100}$ of a grain without difficulty. After taking this minute dose for two or three weeks, and nothing else, for a dilated and hypertrophied heart beginning to fail, he said to me: 'I don't know what benefit you expected from the treatment, but I know what I have received. I can go upstairs much easier than I used to do.'"

"Arsenic," he also says, "may be given alone, and in anemic and very sensitive persons who can only tolerate a very minute dose this is often the best way of employing it."

As Moir remarks, we find here, in Balfour's recommendation, the similar relations, the small dose and one medicine at a time.—*Journal of the Brit. Hom. Society*, April, 1899.

LYCOPodium IN RHEUMATIC FEVER.—Dr. Moir states that some years ago there was a letter from an Australian *confrère* recommending lycopodium in rheumatic fever, and he has since had some very satisfactory results from its use in controlling the febrile condition. Before he had, in ignorance, always associated lycopodium with chronic conditions; but on turning to Hughes he found that the tincture had produced inflammatory rheumatism of arm, wrists and forefingers, and Hughes himself had found it of benefit in a case of aneurism.—*Journal of the Brit. Hom. Society*, April, 1899.

CACTUS GRANDIFLORUS IN RHEUMATIC CARDITIS.—Moir, of London, does not think that cactus has been given the attention it deserves as a remedy for the heart complications of inflammatory rheumatism. The drug was first used by our school, although of late it has been generally taken up and recommended as "a valuable cardiac nervine and tonic in five minim doses," and there is also a large sale of "cactina pellets." It was introduced to practice by Rubini, of Naples, who proved it upon himself and his wife, and in his pamphlet, which was translated by Dudgeon in 1864, he states that "my wife and I, on perceiving how powerfully it acted on the heart and circulatory system, causing the shedding of tears and feelings of terror, had not the courage to go further in experiments which might endanger our lives." He expressed a hope that others with more fortitude and less timidity would be able to complete and correct whatever symptoms had not been accurately described, but these heroic powers have not appeared and we are sadly in need of proving this and other drugs with the results tested by the modern instruments of precision.

Dr. Moir would place the action of cactus as midway between that of aconite and digitalis. It certainly seems to control the inflammatory condition and at the same time to strengthen the heart contractions. In its provings it seems to have the power of producing peri- and myocarditis, and to give a better picture of the rheumatic carditis than any other drug. He has used it lately with good results, and hopes soon to have definite statistics to lay before the profession. So far it has had a better reputation with us for functional diseases of the heart, but he thinks that is because we have not attended to the directions of Dr. Rubini, who advised that in organic disease of the heart it should be given in doses of from 1 to 10 drops of the tincture, and in nervous diseases of the heart in the 6th, 30th and 100th dilutions. For the rheumatic heart Dr. Moir would advise 2 to 5 drops of the ϕ tincture, according to the age of the patient.—*Journal of the Brit. Hom. Society*, April, 1899.

THE OBJECT OF TREATMENT OF PNEUMONIA.—According to Snader, of Philadelphia, since we cannot annihilate the micro-organism we make it an object of treatment to modify the results of germ activity and the soil they occupy. The local condition of the lung may become the object of treatment:

1. To modify the amount of blood going to the already congested area in

order to limit the amount of subsequent consolidation and its train of mechanical consequences.

2. To liquefy the tough adhesive inflammatory products in order to lessen severe cough and its consequent increase in pulmonary pressure and sequential back-pressure on the heart.

3. To remove, speedily, products of inflammation from the air-cells and bronchi.

4. To prevent extension to uninvaded lung territory.

5. To prevent embolism, suppuration, abscess, gangrene, pulmonary fibrosis, extensive secondary pleurisy.

6. To overcome chest-wall paresis.

7. To prevent pulmonary œdema.

All these facts are reasonably within the control of a wide-awake therapist, and individualization is the keynote of success.—*Medical Era*, May, 1899.

F. MORTIMER LAWRENCE, M.D.

RANUNCULUS SCCLERATUS.—This drug resembles *ranunculus bulbosus*, but it possesses more irritating properties. It gives rise to a vesicular eruption on the skin, which, with large bullæ, on breaking discharge a yellowish and clear fluid, which is so acrid that it irritates the surrounding parts. Therefore, it is better indicated than the *ranunculus bulbosus* in pemphigus. On the tongue it produces the *lingua, geographica*-mapped tongue. This state is noticed in typhoid fever and diphtheria, and may be indicative of other remedies, as *natr. mur.*, *arsen. alb.*, *rhus tox.* and *taraxacum*; but none of them have the burning and sense of rawness of the tongue which is characteristic of *ranunculus sccleratus*.

In the abdomen this drug produces pain, sensitiveness in the region of the liver, with a feeling as if diarrhœa were about to come on.

In the chest there are sensations of having been bruised and weakness in the morning, and at the same time a sensitiveness of the skin of the chest. There is fluid coryza, with sneezing and pains in the joints, and pain on mic-turition.—*Revue Homœopathique Française*, tome ix., No. 6.

PULSATILLA IN HEADACHE.—Dr. Makechnie reports the case of a dress-maker of 19 years, who complained of frequent and temporary attacks of headache, which recently had been recurring quite frequently. They had been appearing of mornings, and were aggravated from movements of the head, but not by bending forward or stooping. Besides this, the patient had been suffering from a vesicular eruption at the corners of her mouth. Her appetite was poor, she could not bear much food, and her hearing, usually good, was affected. Restless sleep, with many dreams, and dyspnoea on going up stairs (anæmia). After a few doses of *pulsatilla* 3x the pains decreased, finally to disappear altogether.—*Vratch Gomeopat*, Sent jabrij, 1898.

SECALE CORNUTUM IN THREATENED ABORTION.—Dr. Lambreghts, Jr., of Antwerp, treated a woman of 24 years, a peddler, who, in miserable health, had been married for three years, and, though she had aborted twice during one year, had not borne a child. With an invalid husband, chloro-anæmic, dyspeptic, oppression of the chest, palpitation, leucorrhœa and backache, she received treatment at the Homœopathic Dispensary of that city. She became

pregnant, and was advised to give up her business. At the tenth week of pregnancy she was taken suddenly with hæmorrhage and pains in the abdomen, as in her previous abortions. Sec. corn. 3x, two drops every half hour, was given. The hæmorrhage gradually decreased, and the pregnancy continued. She was eventually delivered of a child at full term. The writer cites another similar case where this drug rendered him equally as useful service.—*Journal Belge d'Homœopathie*, No. 4, vol. v. I have employed this drug with good results in similar cases, though I must say that I employed its alkaloid, ergotine (Bonjean).

A FEW INDICATIONS FOR ANTIPYRIN.—Dr. Marc Jousset, of Paris, from a study of poisonings and overdosings with antipyrin, sets forth the following characteristic symptoms :

Collapse.—Collapse and prostration are two very prominent symptoms of the remedy. They may be accompanied with profuse sweating, fainting and cyanosis. Dr. Bhaduri employed it in the sixth decimal dilution in the collapse of cholera when carbo veg. had failed.

Skin Diseases.—It appears to be indicated in all affections of the skin accompanied by itching. Urticaria seems to be the most characteristic skin lesion, and especially in the violent forms, where there are intense itching and swelling of the skin. It may be used in eczema and polymorphous erythematæ.

Eruptive Fevers.—Scarlatina and measles are the two cutaneous affections where it seems to be mostly indicated, for there are a great number of symptoms that point to its usefulness here, particularly in measles.

Measles.—Fluent coryza, violent sneezing, lachrymation and injection of the conjunctiva ; a measles-like eruption, followed by a furfuraceous desquamation.

Scarlet Fever.—Tonsillitis, with whitish patches on the tonsils ; a scarlatiniform eruption upon the skin, with desquamation.

Ultero-Membranous Stomatitis.—The remedy appears to be very much indicated in these cases—swelling, burning, and crawling in the gums and the soft palate ; painful ulcerations on the lips and tongue, with salivation.

Tonsillitis.—Inflammation and swelling of the left tonsil ; false membranes ; pain on swallowing, with expectoration of fetid pus.—*Journal Belge d'Homœopathie*, No. 3, vol. iv., 1898.

TREATMENT OF DIFFICULT DENTITION IN CHILDREN.—Dr. Manuel Cordova y Aristi, of Mexico, recommends the following remedies in the deviations of dentition in children :

Aconitum.—Fever, agitation, insomnia, a liquid diarrhœa with mucous or sanguinolent evacuations. The child cries constantly and experiences no relief in any position.

Belladonna.—In cerebral hyperæmia, convulsions, photophobia. The child awakens with a jump and looks about with anxiety. Timidity and alertness. If nervous symptoms predominate and the face is pale instead of red, then hyoseyamus is preferable.

Calcareæ Carbonica.—Tardy or slow dentition in scrofulous children and those with feeble constitutions, with liquid evacuations which may be slimy or viscid. Confirmed rachitis and cold feet.

Calcareæ Phosphorica.—According to Schuessler this is the principal remedy in dentition with rickety symptoms and open fontanelles.

Chamomilla.—This is the best remedy in disturbances of dentition. The child's mouth is dry and hot, the cheek bones red, agitation which is ameliorated by carrying the child about on one's arm; jerking of the limbs; nervous irritability; liquid diarrhœa which is clear or greenish, with aggravation during the night.

Cina.—The abdomen is hard and swollen, grinding of the teeth; nocturnal enuresis, the child scratches its nose. Attacks of coughing as though it had whooping-cough.

Coffea.—Excitability, persistent insomina, slight fever, the child is at one time sad and at another happy. It may be alternated with bell. if the nervous symptoms aggravate.

Ignatia.—Convulsive seizures without fever, heat or perspiration. The child awakens fearful, cries and trembles.

Ipecacuanha.—Vomiting immediately after having nursed; diarrhœa liquid and greenish. This remedy may be alternated with bryonia if there be symptoms of bronchitis with fever, cough and expectoration of mucus, or with mercurius if there be diarrhœa of a dysenteric character with tenesmus, scanty evacuations which are slimy and streaked with blood, and at the same time an increase of saliva.

Sulphur.—In scrofulous children who do not respond to the indicated remedy. Whitish and irritating evacuations with irritation of the anus.

Colocynthis.—Colic which forces the child to bend double, with accompanying diarrhœa or constipation.

Kreosotum.—A specific in the dentition of rachitic and irritable children. (Teste).—*La Hœmœopathie de Mexico*.

CHELIDONIUM AND CANCER.—Dr. Bellairs, of London, calls attention to the popular use of chelidonium in Russia and England in treating warts and similar papillary excrescences of the skin. Dr. Denisenko has treated seven cases of cancer with small doses of the drug of the juice, administered for a long time.—*The Hœmœopathic World*, No. 5, 1898.—A number of Russian and a few German writers have reported their experiences with chelidonium in cancerous affections. The results were variable. Though a few reported ameliorations, others obtained no results from its use. The latest is a report by Dr. N. Ivanoff, of Gjatsk, Russia, who employed the alkaloid chelidonine. A woman of 52 years, with a cancer of the stomach, was in a state of extreme marasmus. She suffered from violent pains localized in the region of the stomach, and vomited everything that she ate, so that it was necessary to feed her by the rectum. The vomited substances resembled coffee-grounds, and the liver was enlarged and its left lobe presented a prominence which was very sensitive to pressure. The existence of a malignant neoplasm was not to be doubted. It was probably a cancer of the pylorus with a metastasis into the liver or adhesions between this organ and the stomach. Under the influence of the sulphate of chelidonine, in cachets, 10-15 cgms., twice a day, the condition of the patient rapidly ameliorated. The vomiting, which had persisted for three months, ceased after twelve days, the painful prominence upon the liver as well as the enlargement of the stomach decreased, and her appetite improved. She was soon able to feed herself by the mouth and to get up. She has fleshed up and feels very well. Yet the persistence of the hepatic tumor indicates the continuance of the morbid process.—*La Semaine Mœdicale*, No. 50, 1898.

PILOCARPIN IN INFLUENZA.—In a communication to the *Philadelphia Medical Journal* (February 11, 1899), Prof. Roberts Bartholow submits his method of treating influenza. It consists essentially, he avers, in the adaptation of physiological actions to the relief of pathological processes—in the inhibition of a morbid state by the principle of physiological antagonism!

After this clear confession of faith, Prof. Bartholow proceeds to outline his treatment. When an attack of influenza occurs, the initial symptoms are dryness and redness of the mucous membrane, soon followed by increased secretion and a general "malaise," supposed to coincide with the deposit and vital activity of minute organisms, and the production of ptomaines. The remedy which is best suited to antagonize this local affection and to prevent the systemic disturbance is pilocarpin. It is his practice to administer, at the beginning of the local inflammation, one-sixth of a grain (adult dose) of one of the salts. "The effects of this remedy, whilst on superficial view similar to the disease, nevertheless quite exactly antagonize it. Pilocarpin sets up a brief stage of dryness, immediately followed by increased secretion, and presently the mucous glands, the salivary and cutaneous sweat-glands, pour forth an abundant secretion. This similarity of action is truly an action of antagonism, for the morbid process and the action of the remedy contend in the tissues, and one or the other must yield. In fact, a sufficient dose of pilocarpin, administered at the right time, will often abort an acute catarrh or a common cold."

Later on in the course of the disease, Prof. Bartholow has recourse to du-boisin, iodid of iron, and the inhalation of volatile substances. We pass over these details, however, in order to congratulate him upon his clear explanation of the action of this highly successful remedy. Without it he might have been suspected of being a practitioner of homœopathy.

SANGUINARIA IN OVARIAN NEURALGIA.—Dr. Ord was consulted by a girl of 22 years who had formerly been healthy and had menstruated regularly, but who for fourteen months had suffered from severe pain in the right side of her abdomen, which greatly hindered her getting about, and which was aggravated at the time of the menses. This appeared every two weeks and required her to take to her bed, while there would be a profuse, bright red flow and severe accompanying colic. The right ovary was very sensitive to pressure. She had been treated in a hospital for four months without success, and bell., nux and hepar had given no results. Sanguinaria 1x was prescribed, and in fourteen days there was a decided improvement and in six weeks a complete recovery.

CHRONIC PALPITATION OF THE HEART AND GLONOINE.—Dr. Ord observed a young unmarried woman of 26 years, who, of a lively and fiery temperament, who greatly enjoyed exercise, after an attack of grippe began to suffer from palpitation of the heart, which would appear at the slightest cause, the pulse increasing to 120, with very noticeable pulsation of the blood-vessels, so that the carotids, for example, were seen to pulsate. These attacks of increased heart's action were always associated with heat and redness of the face and pain in the left side of the thorax. At the same time she was very nervous and apprehensive. Simultaneously, disturbances of digestion and of the stomach set in; trembling and distress on movement. He ordered glonoine 6x, and in one month all the symptoms had disappeared.

FRANK H. PRITCHARD, M.D.

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HOW TO ADMINISTER THE INDICATED REMEDY.

BY GEORGE ROYAL, M.D., DES MOINES, IOWA.

(Read before the American Institute of Homœopathy, Atlantic City, June 20, 1899.)

WHEN I began teaching *Materia Medica*, I gave no instructions as to the manner of administering the indicated remedy. There were two reasons: 1st. Because I considered the subject of little importance. 2d. Because it seemed to me that what little attention the subject did demand belonged either to the chair of theory and practice or to the preceptors of the students.

A more extended observation, however, has shown me that homœopathic physicians follow no general rule in administering remedies. More than that, I am convinced that many times the properly-indicated remedy has failed to cure because, either through the ignorance or carelessness of the physician, it has been *improperly* exhibited.

Therefore I want, at this time, to enunciate two or three general propositions, and, after hearing your opinions, formed from experience, I hope I may be able to formulate a few rules which I can give my classes for their guidance.

My first proposition is: That all remedies should be so exhibited that they will reach the objective point in as short a time and with as little change as possible. By change, I mean alterations from contact with vitiated secretions or excretions of the body, dirty spoons, dishes, etc.

This at once raises the question as to whether remedies act best in powders, solution, triturate-tablets, emulsions, or some other form.

To my mind, there is no doubt that the great majority of our drugs will act most promptly and effectively if given in solution.

When a quick response is wanted, I notice physicians give their remedies in water. I have demonstrated the truth of the above again and again in my own practice. Most of our remedies, even if carried in other forms in our cases, can be and should be dissolved in water when left for the patient's use.

Those who listened to Prof. Bailey's paper at Omaha last year, or have since read it, I think will find therein a scientific reason for this method.

At this point I want to enter my earnest protest against the use of triturate-tablets. It is true that they are more convenient for both physician and patient, but I do not believe they are either accurate or scientific.

The second question which my proposition seems to raise is whether, after the drug is dissolved, it shall be administered by olfaction, inunction, hypodermically, or by the mouth or other orifices of the body.

In regard to the *method* of administering the remedy, the physician has greater freedom of choice, with more assurance of success, whatever his choice, than when the *form* of the drug is under consideration.

The stale, old story of the homœopathic physician who cured his patient by a few inhalations, and who was amply paid by the said patient permitting him to smell of his wallet, is still being circulated and enjoyed by the physicians of the dominant school.

And yet I fail to see why moschus, melilotus, euphrasia, allium cepa, arum tri., and others of that class, should not be administered by olfaction with as good results as amyl nit., chloroform or ether, when so administered. The only question to be asked is: "In which form will the remedy act most rapidly?"

Could I have a hypodermic syringe for each drug, I should always administer my remedies to adults hypodermically. Why? Simply because the remedy is thrown at once into the

circulation, and is not contaminated by vitiated secretions or other antidotes.

It is surprising how thoughtless some otherwise careful and skilled physicians are in regard to this subject of removing any substance which may interfere with and prevent the indicated remedy from getting into the circulation. Of such importance do I consider it, that with your permission I will illustrate my point by relating two cases:

I was called, in consultation, to see a patient suffering from typhoid fever. The attending physician was a good prescriber. More than that, he usually employed the medium or higher potencies. The patient's tongue and the mucous membrane of the mouth and throat were covered with a heavy black coating, and were as dry as a chip. The teeth were covered with sordes of the same character. We agreed to give *ars. 2c.* Imagine my surprise to see the doctor take from his pocket-case a small vial of No. 10 pellets, medicated with the remedy, and put eight of them on the patient's tongue, and then make up ten powders of the same, one to be given every three hours. The doctor could not expect to get results from suggestion, because the prostration of mind as well as body was so great that the patient was completely unconscious of what was going on around him, although very restless. The doctor might as well have put his eight pills into the patient's hair. Thinking his work done, the doctor turned to me and said: "Any other suggestion before we go?" My reply was: "Have the nurse moisten and clean the man's mouth. Give him a few spoonfuls of clear water, then put ten drops of the *ars.* into a tablespoon of water, and give it every three hours, always cleaning and moistening the mouth before giving."

CASE II.—A 6-year old boy, with a stomachful of haws, after great suffering, went into convulsions. A doctor called, who gave *nux v. 30th*, in water, a spoonful every half-hour, and left the patient, probably, to die. The doctor was recalled, and I was called in consultation. A tablespoonful of mustard-water brought up a pint basinful of undigested haws. The *nux*, after that, had an opportunity to act if it was needed, and the child was eating hard, green apples the next day.

Dr. Banten, of Waterloo, Iowa, used to tell about "preparing his patient for the remedy." In reply to an inquiry as to

what he meant by "preparing a patient," the doctor said: "As the old Yankee farmer used to prepare his barn floor for threshing by removing everything and sweeping it thoroughly, so I give castor-oil, Tarrant's aperient, or hot water, to cleanse the mucous membrane of the digestive tract before giving the indicated remedy."

Therefore, whether you think the drug will reach the seat of the trouble quicker through the mucous membrane of the nose, mouth, stomach, rectum, or through the absorbing surface of the skin, be sure and see to it that these media are put into the best working condition possible.

My second proposition is: The remedy should be administered in the most suitable potency. I am going to say but little on this proposition. The potency question always brings out an amount of useless talk in all associations, so it will be dismissed now with the statement that when the chemists ascertain which potency gives us the greatest number of free ions, *that* will be the potency in which to exhibit the remedy. Until that is done, we can only give a few general directions, viz.:

1st. The metals should always be given in the 30th, or higher.

2d. For chronic cases, use the higher potencies.

3d. Nervous, susceptible patients should never be given strong, crude drugs in the lower potencies.

The third proposition is: That after improvement has begun, the dose should not be repeated so long as that improvement continues.

This would seem to make the question of repetition of dose a very easy one. Could we always be assured that the single dose would cause improvement, and that immediately, it would indeed be easy to formulate and apply a rule for the repetition of the dose. But, alas! we are not infallible. We do not, in all cases, know positively that we have selected the indicated remedy. And again, all indicated remedies are not equally prompt in their action. This adds to our uncertainty as to whether we have the right remedy, and raises the following questions:

1st. Shall we change the remedy if we do not get improvement after giving one dose?

2d. If not, but on the other hand if we are going to repeat the dose, how frequently shall we repeat while waiting for improvement?

3d. In either case, how long are we to stick to a remedy in order to demonstrate whether or not it be indicated?

We would all say *no* to the first question provided we had carefully prescribed and nothing new had occurred to change the symptoms. I think this principle is clearly taught by Hahnemann in the *Organon*, and also by the experience of all present.

A rule which could serve as an answer to the second question would read something like this: Those drugs which, in the provings, produce symptoms in the shortest time must be repeated most frequently as remedies. A few exceptions to this rule would be such active poisons as *mercurius cor.* or nitric acid. This necessarily implies familiarity with the day-books of the provers. To illustrate my point I will ask you to recall the provings of *glonoine* and *lilium tig.*, as representatives of the two extremes.

Seconds are used to measure the time before *glonoine* produces symptoms, and the effects disappear after a few hours, at most. On the other hand, hours are used in measuring the interval which elapses before *lilium tig.* produces symptoms, and some of these symptoms continue for weeks. So much for the rule as applied to the provings. Now let me cite two cases to prove the applicability of the rule or the "working part of it," if you please.

A physician came to me and said: "My mother suffers from headache. There is intense throbbing. There is fullness. The face is usually red, once in a while pale. The pulse is quick and full, and every beat increases the pain in the head. Stooping and moving also aggravate. This dates back five years to getting overheated. Now, don't say *Glonoine*, because I have tried it high and low, and the only result is a little alleviation for a few minutes after each dose, whether the remedy be given in the 6th or 200th." He had given it during the intervals between the attacks. In answer to my questions, he stated that two hours was the shortest period between the repetition of the dose. The attacks would last anywhere from eight to twenty-four hours. The suggestion to give a dose every

half hour, to begin with the first symptom, was acted upon. The result was that the duration and severity of the attack were much decreased, while the intervening time was much increased, till after about six months the cure was completed.

Another physician came with this group of symptoms: "The bearing down, a weight in the pelvis. Frequent desire to urinate. The hurried feeling and the pain and fluttering about the heart." I asked if he had given *lilium tig.*, and he answered, with a good deal of warmth, "No, I tried *lilium tig.* years ago in several cases, but never received any benefit from it." When asked how long he had continued the remedy, he replied, "In one case four days." He promised to give a dose twice daily for four weeks and report. As the patient was his own unmarried daughter I knew he would keep his promise. The result was a complete cure. To the objection which might be raised that such a rule would require much time and study of *materia medica*, and make that already intricate study still more difficult, I would reply that in order to master and skillfully use our *materia medica* hard study is necessarily required, but that the additional work which this rule would involve is more apparent than real. One who, for the sake of remembering his symptomatology, is in the habit of grouping his remedies according to the conditions (diseases) for which they are most frequently indicated, will find no great difficulty in classifying all remedies into two groups. Into the group which acts promptly he would put the gases, volatile oils, volatile salts, and all compounds containing gases and oils; also acids and all those remedies which act directly upon the nervous system. For an example, of each let us take chlorine, oil of almonds, prussic or carbolic acid and aconite. In the other group we would put the metals, minerals, and all the so-called tissue remedies. Examples, *argentum met.*, *calcareo carb.* and *sepia*. The exceptions to such a classification would be few and could be easily remembered. The benefits derived from the knowledge and application of such a rule would be immeasurable.

In conclusion, I will say a word concerning what is commonly called adjuvant or auxiliary treatment. Students often ask whether it is homœopathic to use external applications to assist the remedy. The reply is that the use of external applications has nothing whatever to do with Homœopathy. We

know the effect of heat and cold. If we are giving a remedy to reduce congestion or inflammation, and can hasten the process by the use of hot or cold water, we are in duty bound to use it, not as homœopathists, but as physicians. We should always bear in mind, however, that nothing should be used which is inimical to the remedy, or that will mask or obscure our symptoms.

THE TREATMENT OF SARCOMA BY THE MIXED TOXINS OF ERYSIPELAS AND BACILLUS PRODIGIOSUS.

BY H. L. NORTHROP, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the County of Philadelphia, March 9, 1899.)

“SMALL favors thankfully received” expresses, in common parlance, my gratitude to Dr. Wm. Coley, of New York, for the introduction of the mixed toxins of erysipelas and bacillus prodigiosus in the treatment of inoperable sarcoma. I say “small favors” because there have been many failures. But if there is anything “under the sun” that will cure a sarcoma ever so rarely, that will control and remove one of the most hideous *bete noirs* of afflicted humanity, everybody, doctor and patient, should know of it. To quote from one of Coley’s articles, “the successful cases, a number of which have now remained well beyond three years, more than offset the many failures.”

For the history, method of use and effects of the injection of the mixed toxins I must refer you to Coley’s numerous articles published during the last five years. It is not my intention to present this subject comprehensively, nor to report even a single case of cure by this inoculation method. Indeed, I shall speak of a couple of failures. I am anxious to have this form of treatment kept before the profession, and I trust that at a later day I will be able to offer a satisfactory report on the subject to this Society.

In *The Medical Record* of August 27, 1898, appeared an abstract of a paper by Coley with the following title: “The Treatment of Inoperable Sarcoma with the Mixed Toxins of

Erysipelas and Bacillus Prodigiosus; Immediate and Final Results in One Hundred and Forty Cases." After referring to the use of the toxins as a prophylactic measure, the method of preparing the toxins and technique of administration, the dosage, sterilization of the skin and needle, duration of treatment, dangers of the treatment, successful cases treated by this method by other surgeons, Coley offers the following conclusions, which are in almost perfect accord with those recently published by Moullin (*Lancet*, February 5, 1898):

1. A considerable number of inoperable sarcomata, the correctness of the diagnosis of which is beyond question, have entirely disappeared under this treatment.

2. A large proportion of these cases have remained free from recurrence more than three years after treatment—the period which has generally been accepted as of sufficient length to justify their being regarded as permanent cures.

3. Different varieties of sarcoma differ widely as regards the manner in which they are acted upon by the toxins. The results thus far show the treatment to be most successful in the spindle-celled variety, one-half of the spindle-celled sarcomata so far treated having disappeared. Round-celled sarcomata yield less readily, although a certain number have been successfully treated. No case of melanotic sarcoma has, up to the present time, shown more than a slight improvement.

4. The action of the toxins upon sarcoma might be regarded as a rapidly progressing necrobiosis with fatty degeneration. This action is not the result of inflammation, nor does it resemble the destructive action of a local escharotic, but it is rather specific in character, exerting a direct influence upon the tumor cells.

5. The specific action is further confirmed by the fact that several tumors have entirely disappeared when the injections were made subcutaneously remote from the tumor.

6. This method of treatment is attended with a certain amount of risk, unless certain precautions are taken. The chief dangers to be guarded against are: (1) Collapse from too large a dose of the toxins or from injections into a very vascular tumor. (2) Pyæmia from insufficient precautions as regards asepsis, especially in cases in which there is a granulating or sloughing surface. (That the risks are small is shown by the

fact that in upward of two hundred cases treated personally, death was caused by the injections in but two, one of which was so nearly moribund that no treatment should have been begun.)

7. The use of small doses of the toxins for a short period after primary operation, as a prophylactic measure, theoretically, has much to recommend it, and if proper precautions be observed the treatment should be practically free from risk.

8. The action of the toxins of erysipelas upon sarcoma, as shown by clinical results, is in strict accord with the known action of the living streptococcus of erysipelas; therefore the method has a perfectly logical and scientific basis.

In support of Coley's last conclusion, that the use of the toxins is logical and scientific, and in full accord with the action of the living streptococcus of erysipelas, permit me to report the following case:

Mrs. F., æt. 80, had a melanotic sarcoma of large size removed from the right nasal cavity by Dr. I. G. Shallcross, in September, 1893. She was thereupon admitted to the Hahnemann Hospital, Philadelphia, where a melanotic sarcoma the size of a chestnut was removed from the right side of the neck. In February, 1894, she returned with two tumors the size of robins' eggs, located behind the sterno-mastoid muscle. These were easily removed and the patient was sent home. In March, 1894, there was an extensive recurrence in this same locality. Again admitted to the Hahnemann Hospital, she presented an elongated mass on the right side of the neck in the line of the sterno-mastoid muscle, reaching from a point about a finger's breadth above the clavicle to an inch below the ear. This growth was deeply attached, was not adherent to the skin, and extended inward to near the middle line of the neck.

There was no doubt in our minds regarding the nature of this mass, as the woman's history was too decidedly that of sarcoma to permit of anything else being considered. An incision under ether revealed an extensive sarcomatous infiltration. The case was inoperable, and the wound was closed. Eleven days later her temperature suddenly reached $101\frac{2}{3}^{\circ}$, pain appeared in the right side of her face and neck, and the skin here became fiery red and the neck tissues swollen, pitting on pressure. The complication was promptly diagnosed as ery-

sipelas, and the effect upon the sarcoma was watched with great interest. The attack subsided, and in nine days more the growth had become considerably smaller, and was more movable. Before the attack of erysipelas our patient suffered severe pain; this had now entirely disappeared, and her general condition was greatly improved. Two weeks later all macroscopic indications of sarcoma were gone, and the patient was discharged from the hospital. In July of the same year Mrs. F. returned for the fourth time. Three tumors were now removed from the sheath of the common carotid and internal jugular, and a small sarcoma was enucleated from the inner side of the right-cheek wall. Her wounds healed nicely, and she left the hospital in good condition. We have not heard from her again, so she is probably dead.

My object in detailing this case of multiple recurrent sarcomata is to show the effect of an attack of erysipelas upon sarcoma—and a melanotic sarcoma at that. Coley says no case of melanotic sarcoma has shown more than a slight improvement under the toxin treatment, and I suppose we are not justified in claiming that the patient above referred to was more than *slightly improved*. But she enjoyed immunity for a longer period of time after her attack of erysipelas than after the mere mechanical removal of the neck tumors.

In July, 1898, I attempted the removal of a sarcoma from the summit of the left shoulder of Mr. S., who was 62 years of age. This tumor had made its appearance one year before, and had reached the size of a large orange. It was nodular, blue and ulcerated; had infiltrated the soft parts of the posterior scapular and deltoid regions.

I believed it to be an osteosarcoma, springing from either clavicle or acromion. Upon its removal I found it attached to the clavicle and exceedingly vascular. The excessive hæmorrhage prevented the resection of the clavicle, and the surrounding infiltrated tissue had to remain undisturbed. It was necessary to infuse the man, so profound was the shock, though every effort had been made to limit the loss of blood. Notwithstanding the hopelessness of the case, because of the character of the growth and my inability to completely remove it, though remembering that Coley had found the osteosarcomata the least susceptible to the influence of the mixed toxins, I de-

terminated to give them a trial. After the first few injections, made into the centre of the new tissue (sarcomatous), which had rapidly grown from the clavicle, and which was infiltrated with calcareous material, considerable local and general improvement was noticed. The wound finally came to a standstill, however, the patient failed, mentally and physically, and died.

The toxins were used in this case faithfully and persistently, the injections being made directly into the new growth overlying the clavicle, and strictly according to Coley's directions. Because of the specific character of the tumor, already described, no improvement, much less cure, was expected.

Dr. P. Sharples Hall reports as follows the microscopical nature of this growth: Tumor composed of small, round cells, imbedded in a very scanty and delicate stroma. The blood-vessels are numerous, both large and small, the walls in many cases being composed only of the tumor cells. Hæmorrhage quite common; also considerable degeneration of the tumor cells. Diagnosis, small, round-celled sarcoma.

THE NUX VOMICA PATIENT.

BY FRANK KRAFT, M.D., CLEVELAND, OHIO.

(Read before the Ohio State Homœopathic Medical Society, Springfield, May 9, 1899.)

IN the street vernacular of the day, the nux patient ain't no fool. He is rather more of a conscious and malicious liar than the veratrum or the anacardium patient. We say belladonna is rarely indicated in idiots, so we say that nux is rarely indicated in stupids. Indeed, it is one of the leading characteristics of nux that he is bright and conscious even to the last. He knows what's what. As a rule, he is gifted with good horse-sense; but at times, owing to troubles below the belt, it gets severely twisted. He is a fine workman, working in fine and delicate things. Engraving, for instance; hence, look for nux patients among forgers and counterfeiters. He has the conscience of the City Editor, recently described in *Scribner's Magazine*, which governs by turns of acerbity and irritability;

then remorse. He will give sarcastic directions, distorted instructions, and then, in the next fifteen minutes, try to undo his meanness in some way, but never by apologizing to the victim. He is a great planner and plotter. Needless to add that his plannings and plottings are not always governed by sentiment or love. There is very little of the coward about him physically. He is a fighter. He has the two-o'clock-in-the-morning courage. He is the little dog which attacks the biggest mastiff that comes in its front-yard. He is pretty often the under-dog. But he doesn't know when he is whipped—just as some people, in the profession and out, don't know they are dead. He is capable of love, but mostly with a string to it. He is fond of the dear public, but his *pro patria* may be due to the flesh-pots of embalmed beef. And his love may be built on the same order—for revenue only. He is a great specialist for tabular and statistical greatness only. Yet he may be honest about it, and believe that he is a moon-struck lover, or a mouth-of-the-cannon patriot, or a disinterested, unselfish hysterectomer, with no special eye single to the glory of No. 1. He goes by contraries. He must not be crossed, else he becomes the crossest of the cross. The quickest way to incite him to trouble is to oppose him, no matter how good the friend, nor how transparently wholesome the counsel. He wants his *enemy* to tell him the truth. He hardeneth his forehead against reproof. He is not usually a tall person. He may be but a few inches above five feet, but he will swim with his command across a river in the face of a rain of bullets and dislodge and route the enemy. He is neither fat nor sluggish. If he were, he would be more likely bryonia, with surly stupidity; or capsicum, dropping grease and sweat at every step; or pulsatilla, crying because he feels bad, or because he feels good, or because he doesn't feel at all. He is a race-horse, and tireless, and, therefore, lean and lank and hungry-looking. But he gets there. His great card is his adaptability. He always alights on his feet. On the law of homogeneity—oneness—he is as angular in body as in nature. He may have a broad head, but his disposition, when he is sick, is apt to be narrow and mean. He is restless, but not with the itching of rhus, nor the desire to stretch, and be in motion. It is likely his liver. The liver is the biggest part of him. He drinks like a fish—though

I have often wondered whether a fish drank, any more than a dog worked. And his drinks are of all kinds—except water. He partakes of the latter element as sparingly as does the much-maligned Kentucky colonel. Water does not set well with him. He drinks liquors because he is dry, because he is warm, because he is cold, because he feels bad, because he feels good, because his wife has had a new baby, because his mother-in-law is sick unto death—but mostly at some other fellow's expense. He rarely gets "full." He can hold a good deal. His mind will be active in the midst of the bodily debauch. He may not be able to raise his finger, nor articulate a word, but still he is conscious. And long before you can touch his limit he will get sick, emulate the poor Indian, go out, come back, and drink more—at your expense. Therefore, beware of this fellow if you are inclined to take him out to have some fun with him. He eats in the same way that he drinks—everything that comes along, from angel cake to limburger. He gets in trouble shortly after eating. He will then drink more and eat more, just to see if it will make any change in his feeling. He eats in a railway hurry, without appetite, and upon the slightest provocation. He goes to table with a book or the morning paper. He is always ready to eat or drink—principally the latter. His liver is thickened and enlarged. So he takes the liver-color, or, rather, the coffee-color, for his skin's decoration. He is very fond of coffee. Because of his gross irregularities in eating and drinking, and in all the other good things forbidden in the decalogue, he has dyspepsia, and becomes a large user of Lady Somebody's After-Dinner Pill; then the patent-medicines—tonics, bitters, sarsaparillas, celery compounds, saw palmetto, lost manhood dopes, blood rectifiers and reconcilers, Lydia Pinkham, "garbage" (Garfield) tea to overcome his habitual constipation and give him a thorough house-cleaning, or, more properly, an outhouse-cleaning. He uses tobacco in some form, and mostly in excess—not because he really craves it, but because it allays his nervousness. There are some forms of nux patients who are thoroughly saturated with stinky-pipe and nasty dog-leg tobacco and turned-up trousers. But the better class of nux patients, as a rule, smoke but little, and that mostly for company, or because the cigar is given. Rarely a cigarette smoker. He has too much brains for that. Notwith-

standing his ordinary common sense, he has spells of innocence and gullibility that mark the inconsistency of the patient. He will buy a gold brick or invest in green goods. He will guzzle patent medicines by the gallon, then give his picture and certificate for all the Saturday morning papers of this broad land. He may be an ex-Governor, or ex-Secretary of State, or ex-seventeenth assistant cook at the White House in 1845; or they may be any number of hysterical preachers, pleased with a rattle, tickled with a straw, but always ready to give a certificate of character for anything from veracity to cucumbers.

Look at the pictures in the Saturday morning papers, and out of every ten mark seven nux patients. There is nothing smooth or graceful about him. He is not encumbered with the fatal gift of beauty. His hair was black or very dark, but it whitens early. He is rarely red-headed—as to hair, and much more rarely bald-headed. In this latter respect he is like the phosphorus patient with consumption. He is a ladies' man, but from selfish motives—I might say from sensual motives. At times he is a very animalish person. He does not lie awake at night plotting how to entrap some innocent girl, but he will not often go over on the other side of the street if there is something on this side that catches his lustful eye. But it is not love. He began his sexual perversion early in life as a boy, in the seclusion which the cabin grants. His nerves—and he seems to be a bundle of nerves—like a crab's bones, are all on the outside. Therefore, he is always at hair-triggers. Every little word offends; even a look hurts, and makes him fighting-mad. Every little draught gives him a cold. He wants the windows and doors closed. He isn't cold, but chilly. Because of his perfect adaptability, he can stand lots of real cold and lots of real heat. He can wait for a street-car in a driving storm for twenty minutes, shoe-mouth deep in snow, with no worse effect upon his health than increasing his desire to be Ruler of the Universe for about ten minutes. But when he gets thawed out, his nose and lips and fingers, there is also thawed out and augmented his swearing capacity. He can live in the tropics with equanimity and maliciousness. He can live anywhere where he can make himself unhappy and his neighbors uncomfortable. He is quick in everything except calling the doctor and afterwards paying his bill. He is quick-motioned,

quick-thinking, quick-walking, quick-speaking, and quick-swearing. He gets so quick at times with his tongue that he stumbles, and then stutters or becomes speechless. This is one of his chronic sexual troubles—that he stutters there, and becomes impotent. He gets into a great sweat at times from excitement or anger—but he rarely sweats. He has real fear of but one thing, and that is death. Every little ailment brings him quickly to death's door—apparently—just as it brings him to a consciousness of his latter end, both spiritually and earthly. He has a great deal of trouble with his in'nards, especially the lower end. Piles and piles of it. Remember this patient when you must chloroform him. He will take a great amount of it. Don't begin to operate on him until you are absolutely sure he is under. His mind remains bright long after the usual reflexes are abolished. This is that lady patient who, having taken chloroform or vitalized air, or other anæsthetic, and been operated on by the surgeon or dentist or specialist, accuses the operator with improper conduct. And the testimony of half a dozen bystanders, her husband and her mother, will in but little remove the impression of an assault and a subsequent conspiracy to hide the crime. Don't be tempted to flirt with a nux patient in the privacy of your office. Don't give her an opportunity to blackmail you. She may not do so from malice, but from a distorted and twisted brain. You know she wants to get her husband alone so she may kill him, though she loves him dearly. The sexual instinct in her is large, and at times imperious—as it is usual with all constipated people. But it seems to be more mental than sensual. It is more the lust of gratification than the satisfaction of love. But she will afterwards complain of disappointment, incompleteness and disgust. She is not very bloody in her monthly periods—cold and malicious people rarely are. Abundance of blood means flesh and plumpness, pink skin, red cheeks, red lips, sparkling eyes, and an infectious ha! ha! or he! he!

He is inconsistent in most everything, money matters and business matters, as in love matters. He is made of that wooden-headed and sometimes heroic stuff which will die at the stake for opinion's sake, though palpably and demonstrably wrong. He will wear a faded rose in his inside vest pocket to commemorate a long-ago misfit love affair, while at the same time

he will carouse and drink to excess—at some other fellow's expense—and yet cry maudlin tears of love and constancy over his rose. He is not a good sleeper. He may fall asleep in the early evening while reading his book or paper. But you won't have to wake and call him early, mother dear, for he does that himself. Then he goes to sleep again, to wake with the sun shining in his face and a nut-brown taste in his mouth. Then keep away from him! Nothing will be right. He would quarrel with Gabriel about the size of his halo. He is predominantly worse in the morning; therefore, give nux in the evening. He is a bookworm and a hard student, and when well-balanced otherwise will make a great man. Nux people, as a rule, have some little vice that they are anxious to keep from the public. It may be simply in the inclination to cause pain in others. He fights very shy of pain for himself. The Medicis, and the Duc de Guise and old Torquemada, must have been nux patients. All warriors and spillers of warm blood in cold blood are allied to nux patients. There is a good bit of cat about them. This nux patient is your typical actor, author, poet, artist, editor, musician. Erratic and erotic. Will live in a garret for an ideal's sake. Live like an uncrowned king for a few weeks after making a raise on his last curtain-raiser or pot-boiler or grand operation, then return again to his garret and his mansard. He writes, as he talks, as he paints, as he fights, as he marries (if an actor), by fits and starts—when the spirit moves. Jealous as Othello. Treacherous as Iago. Quarrelsome as Katherine in *Taming of the Shrew*. “Biggity” (big-headed) as a recent graduate. Sarcastic and polished as a Frenchman.

In conclusion, nux is a wonderful remedy. It fits the king on his throne and the tomato-can tramp in the haymow. The ruler and destroyer of dynasties, as it does the man behind the anvil and the plow. The bespectacled Lady Principal at the head of the seminary who wets her lips and says “grows” for grass, down to the weeping Cinderella sitting by the potsherd. Youth and age, male and female, cold and warm, all colors and all nationalities. It is, truly, a polychrest. There isn't a prettier remedy in the homœopathic materia medica to lecture upon than nux, unless it is belladonna. It has both form and color. A teacher with a little knowledge of drawing or color

can put the nux face on the blackboard or white paper, and thus impress it indelibly upon the student's mind. And there are other of our remedies that can be easily visualized. Nux is so vast in its symptomatology that I have but touched upon its outermost border. But with this general picture filled in by a live and enthusiastic teacher, aided by a few rapidly drawn pictures, it is, indeed, a very dull student who does not get a better idea of nux than if he tried to carry away a half dozen pages of unrelated symptoms of headache, colic, constipation and corns, read off to him in a droning voice from letter-perfect manuscript.

THE EASY REMOVAL OF PICRIC ACID STAINS.

BY JOSEPH C. GUERNSEY, A.M., M.D., PHILADELPHIA.

IN the June number of the *HAHNEMANNIAN MONTHLY*, page 386, we find these words: "The picric acid treatment for burns and scalds has but two great drawbacks: it stains the skin . . . stains on the hands received when applying the dressing usually last several days, in spite of the vigorous application of boric acid, alcohol, ammonia, etc."

I have used picric acid frequently in burns and scalds, and I do not hesitate to use it with the utmost freedom as far as the "stains" are concerned. I apply my preparation (picric acid, 75 grains; alcohol, 1 or 2 ounces; water, boiled or distilled, 2 pints) on absorbent cotton, and get my hands soaked in so doing.

To remove the consequent stain I take a cake of pumice stone which has been well saturated with water, rub a little soap on the pumice, and then gently rub my hands. All stain promptly vanishes.

COCCULUS IN GASTRIC DERANGEMENT.—Yellow-coated tongue; loathing of food; dry mouth, with or without thirst; fetid eructations, nausea and desire to vomit, especially when talking, after sleeping, when eating, or during motion, particularly riding in a carriage; painful fullness in the region of the stomach, with labored breathing; constipation or soft stools, with burning at the anus; debility, with sweat during the least exercise; aching in the forehead, with vertigo.

THE USE AND ABUSE OF A PARADIGM.

BY R. B. LEACH, M.D., ST. PAUL, MINN.

IN the April issue of this journal I confess to have propounded the supposedly legitimate interrogatory: "*Summa summarum alternationis*?" which, *equivalently* translated, should read: "Is not the following the *one* subterfuge of the alternationists?"

As my question has received no *answer*, but has aroused, in the May issue of this journal, an irrelevant comment by one of the translators of Hahnemann's writings, I will try to present *this* paper so that it may be free of the insinuated "one-sidedness" of the first, as well as free of the insinuated "sophistry almost to the verge of quibbling."

Despite my personal high regard for the recognized acumen of our distinguished colleague from Boston, and despite my personal appreciation of his great assistance to us, who do not understand the German quite as he does, I hasten to *re-assert* that he and *all other* translators of Hahnemann (*i.e.*, those already quoted by me) have *mis-translated* the German words which, *literally* rendered into the English, *all* English scholars will freely admit mean "to alternate," "alternately," "alternating," "alternation;" *i.e.*, the rhythmic rotation of remedies like the rhythmic rotation, or alternation, of day and night, etc.

Dr. Wesselhoeft tells us that "no one who has ever taken the trouble to read, even cursorily, Hahnemann's works, will find there any argument in favor of the absurd routine alternation as practiced nowadays." To this I take exception, for that to any reader, the cursory reader especially, the word "alternation," as used by Hahnemann's translators, implies *routine rotation of remedies*, and *implies* nothing else.

Dr. Wesselhoeft tells us that "there is no question at all concerning Hahnemann's meaning and intent." This I, *personally*, believe and admit; but I believe because of something *more* than mere "cursory reading," for Hahnemann's *meaning*, as *translated* for us, is submerged in the *literal* (here the antonymic

or antithetic) rendering of the German verb, "abwechseln;" in English, "to alternate;" "to rhythmically rotate."

Dr. Wesselhoeft tells us that: "In such cases it is the business of the translator to give the meaning of the author *literally*, if possible." To this I would answer that, *the qualifying clauses considered*, it is *impossible* to convey Hahnemann's meaning through a *literal* translation, and that translators, having given us a *literal*, have given us a *mis-translation* of Hahnemann.

Dr. Wesselhoeft says: "It must be asked what is the English equivalent of the German 'abwechseln' and the Latin derivative, alternirend, if alternation, alternating, from the verb to alternate, is not the equivalent?" To this I would respectfully reply that, as my lexicographer defines it, "an equivalent implies *alike in significance*; interchangeable; synonymous;" and that, with this before us, I would also respectfully ask: "Can our colleague form us a sentence containing "to alternate" (*i.e.*, to rhythmically rotate), and still have that sentence imply, "to *not* rhythmically rotate;" "to *not* alternate;" and, if this cannot be done, *why disregard clauses which define intent?*

Dr. Wesselhoeft says: "There is no question at all concerning Hahnemann's meaning and intent." Yet Hahnemann's translators have *made* a question out of "no question" by *not considering* just those qualifying clauses (before choosing their English word), which same clauses determine (or *should*) the difference between a *literal* (exact) translation and a translation "*alike in significance*." I therefore *re-affirm* that "abwechseln" ("to alternate"), *equivalently* rendered into English (*i.e.*, the qualifying connections being considered), means just the opposite to "to alternate;" that it means or denotes a *choice*; a *selection*; an *election*; an *option*; that it means and denotes just what *alterna-tive* and what no other, except a *synonymous, English* word means.

I claim (and I think with justice) that Hahnemann's interpreters have not first correctly *interpreted* for themselves his verb "abwechseln" and its parts; that they have *not* interpreted to us his *intent*, his *meaning*; that they *have* rendered us a *literal*, a *not-free* English translation; that they have *mis-translated* Hahnemann.

My authorities tell me that: "To translate is to express the *sense of* in another language; to interpret; to explain; to *make plain*." I should like *any* of Hahnemann's translators to show us by what process of reasoning he expects to "express the *sense of* in another language," and *not take into consideration* the qualifying conjunctives of that which he is translating? *Why he should expect of others that which HE fails to observe?*

I submit: A *literal* translation, *only*, of "abwechseln" and its parts has been submitted to the English readers of Hahnemann.

That: A *literal* rendering does *not*, and *cannot*, *per se*, convey to the English mind the *intent*, the *meaning*, the *sense of* the author translated; that it is, in fact, to the non-German mind, *nonsense*.

That: Abwechseln and its parts, *qualified* (*i.e.*, the qualifying clauses *having been considered*), should have been *equivalently* rendered in the English; *i.e.*, should have been *free* of ambiguity; should have "expressed the *sense of* the author in another language;" should have been "*alike in significance*;" should have "explained;" should have "*made plain*;" should have been *freely* translated.

That: English equivalents, and equivalents of English equivalents, *i.e.*, English synonyms, *not* being *un-plentiful*, the translator's lack of that "familiarity with the idiomatic use of *both* languages" (of which Dr. Wesselhoef speaks) savors of a dearth of *something* somewhere.

That: The *non-consideration*, by the translators, of Hahnemann's *qualifying clauses*, has produced for us translations which, consistently considered, make Dr. Wesselhoef's own words ("in *not very infrequent instances* a literal rendering is little better than nonsense") a boomerang which endangers the peace of mind of their progenitor.

That: "The qualifications in the minds of the student of Homœopathy" are, at least sometimes, present; and that the consideration of a worthy and legitimate question calls for *internal interviews*, while the respectful request for the reconsideration of a possible oversight does *not* call for innuendoes.

In re: Dr. Dudgeon's alleged *mis*-translation of Hahnemann (and *his* attempted defence of his untenable position in the June issue of this journal), I will say that: If translators are not

"to render the *sense of* the author translated," are not to consider *qualifying* words, etc., but are to render only a *literal* transcription of the phraseology of the translated writing, their work becomes, indeed, as Dr. Wesselhoeft so aptly puts it, "little better than nonsense;" for if "whichever," referring (as used) to *two* different remedies, does not qualify *both* and specify that *only one* can, from that time on, be considered *at one time*, I, for one, do not understand English, and right now freely admit my imbecility.

If the preposition, *or*, between two words or clauses (as in reference to *aconite* and *coffea cruda*), or the words *then*, and *first*, and *before* (referring to the *successive* curing of syphilis and sycosis and psora), do not *qualify* (or "change the meaning of") other words, phrases or clauses with which they are used, and are not to be considered by the translators, I am indeed confounded at their impudence; for, to me, qualification seems paramount in a translator's language.

I therefore maintain that: *Abwechseln* may mean, and that it does mean, *in the German* (according to the qualifying conjunctions), *either* "to rhythmically rotate" or "alternative" (implying a *choice between two*); while "to alternate," *in the English*, means "to rhythmically rotate," as the rotation of day and night, of summer and winter, and no word, phrase or clause in the English language can qualify or change it; and I also maintain that the promulgator of *Similia* did not mean the rotation of remedies (when he used "*abwechseln*," which means, according to its connections, either to alternate or *alternative*), and this at least one translator admits; and that *any* translator, *changing* Hahnemann's very evident (*i.e.*, qualified) *intent* or meaning, *mis-translates* him.

If, as Dr. Dudgeon says, Chapter 272 of the *Organon* does not refer to the alternation of remedies, but rather refers to "a combination of medicines," it certainly denounces, by implication at least, *any* use of more than "one *single, simple* medicine" *at one time*; for it is a part of "the book of the *law*;" and the *law, proved upon the well first*, demands "like for like;" and there is no "likeness" between the sick man and the rhythmic rotation or the alternation of two remedials; *there are no "provings" upon the well of alternated remedies*; there was no LITERAL "*abwechseln*" practiced in Hahnemann's provings, and

Similia without "provings" is empiricism or "mongrelism" of the worst sort.

I maintain that, together with what I have already stated, the last five lines of Dr. Dudgeon's alleged defence convict him without further comment; for therein he quotes Hahnemann as saying, in the *Organon*, "To cure mildly, rapidly, certainly and permanently, choose, in every case of disease, a medicine [not *two* medicines] which can [by] *itself* [not alternated with another] produce an affection similar to that [not to *those*] sought to be cured."* This "manœuvre for advantage" by Dr. Dudgeon was what we Yankees term "unfortunate," for it neither "fooled" the audience nor answered the interrogator.

I am sorry that I cannot, right here, enlighten the doctor about my word "antonym," which certainly is the opposite of synonym (is, in fact, synonymous with antithetic, and antithetic with synonym); and I am equally grieved to acknowledge that I did not coin the word (for it's a good one); but why I, as well as another, should not, if deemed desirable, coin a word, I cannot conceive; in fact, I have had occasion to, and did, coin my own words, and they were officially recognized.†

I am equally sorry that Dr. Dudgeon interprets the word "rendering" to mean "*sur-rendering*," for Dr. Wesselhoef used this word in the sense of "to translate," and this difference of opinion between the translators (even as to the interpretation of an English word) may not conduce to prove your interrogator wrong, but may, possibly, rather prove "one more straw to show which way the wind blows;" another example of interpreting "the *sense* of the author."‡

As to my having possibly falsified my quotations: Translators who fail to consider the qualifying conjunctives of their author, and who arbitrarily render a *mis*-translation of said author, would easier convince their readers of an alleged error in "the other fellow" by producing proofs than through a surfeit of jargon.

* The words in the brackets are mine.—R. B. L.

† Senate Document, No. 111, 2d Session, 55th Congress.

‡ *The Universal Dictionary of the English Language*, vol. iii., p. 3954. (English edition, edited by Robert Hunter, A.M., F.G.S.)

BRIGHT'S DISEASES.

BY C. R. NORTON, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the County of Phila., April 13, 1899.)

IN considering these maladies I will, to bring the subject out as clearly as possible, divide the usual classifications into :

Acute diffuse nephritis.

Chronic diffuse nephritis.

And chronic non-exudative nephritis, or chronic interstitial nephritis.

The first is the acute form met in connection with some of the infectious diseases, scarlet fever in particular, that occurring in pregnancy, and the disease resulting from exposure to cold and wet.

Poisoning with certain drugs is responsible, too, for some cases.

We find in patients with this acute type of Bright's disease more or less fever, vomiting, œdema, uræmic symptoms, headache or backache, and anæmia. The urine is often smoky in color from the contained blood, the solids are lessened, urea particularly diminished. The microscope reveals a few blood-cells and blood-casts, hyaline and epithelial casts, and kidney epithelium. The urine is diminished.

The following cases are illustrative of this type :

L. K., male; 20 years of age; had typhoid fever six or eight months prior to this time; has a mitral systolic murmur.

October 7, 1898.—Chill in morning with pain under right shoulder; no cough; began to vomit bilious material and mucus in the afternoon. Examination of chest negative; no enlargement of liver; temperature 103°, pulse 124.

He vomited almost constantly during the following night. In forenoon of October 8th, temperature 102°, pulse 128; P.M., temperature 103.6°, pulse 124. Examination of chest revealed no pneumonic signs. Retching nearly the entire day.

October 9th.—Examination of urine showed quantity for twenty-four hours to be 8 ounces; sp. gr. high, urea 16 grains

per ounce; free blood-cells, a few blood-casts, many epithelial casts and a large amount of albumin. Temperature 101° , pulse 100.

October 10th.—Urine 10 ounces; urea 16 grains per ounce; albumin $\frac{1}{2}$ gramme per liter. Temperature in forenoon 102° ; p.m., temperature 102.5° , pulse 92.

Examination of chest disclosed consolidation of base of right lung posteriorly. He was eructating very often, but the vomiting had ceased. Was very dull and sluggish mentally, as he had been for several days.

October 11th.—Increase in the area of consolidation; A.M., temperature 102° ; p.m., temperature 102.4° . Patient brighter and wider awake. Some cough for the first time and a little bloody expectoration (the cough lasted only a day or two); urine 16 ounces.

October 12th.—Urine increasing; still albuminous; epithelial casts; no blood-cells. By October 16th the temperature was normal; on the 21st quantity of urine was 32 ounces, sp. gr. 1027, urea 16 grains per ounce; no albumin; many casts, granular, hyaline and much granular *débris*. On October 28th sp. gr. of urine was 1020; urea $8\frac{1}{2}$ grains per ounce; no albumin; no casts.

Mrs. X., 27 years, primipara; between seventh and eighth month of pregnancy. January 5th urine 24 ounces, sp. gr. 1023, acid, trace of albumin, urea $7\frac{1}{2}$ grains per ounce.

February 6th.—Twenty-four ounces urine, sp. gr. 1013, trace of albumin, urea 5 grains per ounce.

February 22d.—Sixteen ounces of urine, sp. gr. 1025, 12 grains of urea per ounce; urine solid on boiling; large number of epithelial casts; woman very dropsical. Put the patient to bed, ordered milk and toast diet, hot bath at night, Epsom salts in morning.

February 25th.—Forty ounces of urine, sp. gr. 1015; somewhat less albumin.

We were unable from this time on to get the total quantity of urine owing to some being lost at the time of the bowel movements.

She had at about this date several slight attacks of uræmic dyspnœa. The œdema lessened considerably but there still remained a general anasarca. There was no evidence of a collec-

tion of fluids in any of the body-cavities. The urine fluctuated in quantity. There was on March 4th 64 ounces, on the 6th 32 ounces, 8th 14 ounces. Albumin was still very abundant, from 7 to 10 grammes per liter, urea from 168 to 320 grains per day. The hands showed, by presenting swollen, very rosy finger-tips, the interference with the circulation, and the urine contained an abundance of blood, granular and epithelial casts, round kidney cells and leucocytes. The woman was confined March 27th, labor normal with the exception of a too free flow of blood post-partum. She was very much exhausted afterward. On the 28th urine contained 2 grammes of albumin per liter, 6 grains of urea per ounce, and about 48 ounces were passed by means of the catheter. The anasarca speedily diminished, and she had on the fifth day and for a few days thereafter slight septic symptoms, owing, I thought, to an unhealed perineal laceration—the bladder had become infected and the urine contained pus. She had much severe headache and a temperature sometimes as high as 104° F.

Dr. J. N. Mitchell saw her with me at this time and suggested that part of the fever might be due to anæmia, and that she be fed more freely with albuminous foods and the tincture of the chloride of iron be given, in addition to *Chin. ars.* 2x. The fever persisted for a few days, but lessened gradually. We washed the bladder daily with a weak solution of permanganate of potash. On April 7th the temperature became normal. The urine increased and was much clearer. Appetite better. On April 9th there were 48 ounces of urine, sp. gr. 1010, urea 4 grains per ounce, and albumin $\frac{1}{2}$ of 1 gramme per liter.

On April 22d the urine was — ounces, sp. gr. 1019, urea 10 grains per ounce, albumin $\frac{1}{2}$ of 1 gramme per liter, and microscopic examination showed bacteria, many leucocytes and no casts. Patient sitting up and gradually gaining strength. Still taking the tincture of iron and *Chin arsen.* 2x.

The Second Division.—Chronic exudative or diffuse nephritis is more obscure as to its origin than is the acute form. In some instances it results in a continuance of the latter into a chronic state, or it may follow the acute infectious diseases—especially scarlet fever—or may occur during pregnancy. It is supposed, besides, that prolonged exposure to cold or wet may produce it, but it often comes without known cause.

The first symptom noticed is frequently œdema of the face or extremities. The patient is usually anæmic and debilitated, there is headache, indigestion, vomiting, and general failure of health. Uræmia is not so common as in the acute type. The urine is more scanty than normal, of lower specific gravity, the urea is lessened, the albumin often abundant. The microscope reveals many casts, dark, broad, granular; epithelial, broad and narrow hyaline, and leucocytes.

In the later stages of the disease, when the kidneys are undergoing contraction, the heart becomes hypertrophied and the arteries acquire increased tension.

This form is of intractable character, tending to a fatal issue, lasts from six to thirty months, the dropsy gradually increasing, and at the final ending uræmia being often present.

One case, which unfortunately was not recorded, was that of B. W., male, 42 years old. Had been in poor health for some years. In the fall of 1895 I saw him, and found that he had marked general dropsy, with urine ranging from $2\frac{1}{2}$ to 4 quarts, sp. gr. 1012 to 1013, albumin 2 to 4 grammes per liter. He was anæmic, had hypertrophied heart.

His condition fluctuated, being sometimes considerably better and then relapsing. I note that in September an examination of the urine showed 4 pints, sp. gr. 1009, albumin $2\frac{1}{2}$ grammes per liter. He died on October 16th of uræmia. This case must have been in the stage of contraction when I first saw it.

A. H., female, 20 years of age, pale, thin; three or four years prior to my seeing her had for some time albuminous urine, but had subsequently been in good health. About a month ago the patient, having examined her urine, found that it was albuminous. The specimen I examined on October 22d consisted of 25 ounces, sp. gr. 1020, acid, pale yellow in color, slightly turbid, urea 9 grains per ounce, a faint trace of albumin, some leucocytes, no casts. A specimen examined two days afterward showed much albumin and some granular casts. Dr. W. C. Goodno tested the urine a few days later, and wrote me that he believed the patient to have chronic parenchymatous nephritis, being led to this opinion by finding one half gramme of albumin to the liter, small granular casts, a little œdema and a most marked anæmia, and that he did not think that this disease had existed long. This young lady was put to

bed, ordered to take a warm bath at night, to have a diet restricted as to nitrogenous elements, and to take *cantharides* θ , 6 to 8 drops a day.

On March 22d the urine had increased to 32 ounces, sp. gr. was 1031, urea 11 grains per ounce, no albumin, a few leucocytes, no casts.

About a month later I found still slight œdema of the legs; general health much improved; urine 16 ounces, acid, sp. gr. 1027, urea 16 grains per ounce, albumin a trace, bacteria, no casts. A further specimen examined the next day showed upon microscopic examination no casts.

Mrs. T. I., 39 years, one child 8 years old. January 14, 1898, reports that she has been for some time losing much blood from hæmorrhoids. Had a miscarriage three years ago and flooded badly; woman looks very anæmic.

February 24th.—Has been dropsical for a short time. Examined the urine, quantity not stated, sp. gr. 1012, clear, pale, urea 6 grains per ounce, 3 grammes albumin per liter, blood cells, leucocytes, blood casts, wide and narrow, hyaline. She says that she thinks she has passed more urine than was normal for some time. Face swollen, lower extremities œdematous to hips; vulva œdematous also. Sleeps badly, gets up several times at night to urinate. Headache worse at night; accentuated second sound at the aortic valves. On March 13th urine still contained blood casts, granular, hyaline, blood cells and leucocytes.

May 15th.—Sixty-four ounces urine, sp. gr. 1013, a few leucocytes, epithelial cells and possibly some broken down epithelial casts; of albumin there was a trace.

July 28th.—Forty-eight ounces urine, sp. gr. 1012, urea $3\frac{1}{2}$ grains per ounce, albumin a trace.

April 6, 1899.—Sixty-four ounces of urine, sp. gr. 1010, a trace of albumin, no casts, a few leucocytes. I thought at first that this was a case of chronic diffuse nephritis, but question now whether it is not one of chronic interstitial nephritis with an intercurrent attack of acute nephritis.

This woman took *cantharides* θ and *cupr. ars.* 2x for some months. Her diet was restricted as to albuminoids, and she had hot baths at night, later took one of the iron preparations, ferro-mangan-peptonate, but has had no treatment for the last six or seven months.

June 8, 1897.—O. H. W., male, 60 years of age; when called to see patient found him decidedly dropsical, general œdema, pale waxy skin, short breathed, etc. Had been ailing for a long time, was operated for appendicitis eighteen months previously; a few months later had an attack of what I termed, in absence of better knowledge, an abortive typhoid fever, which lasted ten or twelve days. He had had the dropsy for several weeks when I saw him. The urine was 32 ounces, sp. gr. 1017, urea $8\frac{1}{2}$ grains per ounce, albumin 2 grammes per liter, granular and hyaline casts.

July 1st.—Urine 48 ounces, sp. gr. 1013, urea 8 grains per ounce, albumin $\frac{1}{2}$ of 1 gramme per liter. He was feeling a little better, but was still very œdematous.

July 9th.—Died suddenly with acute uræmic convulsions.

We now come to the third division of our subject, chronic interstitial nephritis, often called gouty kidney. This form is essentially chronic and insidious in its appearance. It is more common in the male sex, associated often with the gouty or lithæmic diathesis and with general arterial sclerosis, is often of hereditary origin. Occurs frequently in men of anxious business lives, who are so-called high-livers, of sedentary habit. The early symptoms are obscure; a serious uræmic state frequently develops with great suddenness in those apparently well up to that moment. Symptoms common are headaches, intractable neuralgias, dyspnœa, cerebral apoplexy.

The urine is pale, clear, profuse, of low specific gravity, with small quantity of urea. Changes in the circulatory condition are constant, hypertrophy of left ventricle, general arteriosclerosis.

J. W. P., 62 years, thin, nervous, carpenter. Came under my care in 1896. Examination of heart revealed systolic aortic murmur, pulse slow, radial arteries hard, has had shortness of breathing for a year, left ventricle hypertrophied. Examination of urine showed 72 ounces, sp. gr. 1011, small quantity of albumin. During the next few months increasing feeling of uneasiness and more shortness of breathing developed. Had in September, 1897, a sharp attack of angina pectoris which laid him up for some weeks. Went to Florida late that year and stayed till the weather became warm in the North. Did very well while away. On October 4, 1897, urine 60 ounces,

sp. gr. 1012, albumin a trace, urea 180 grains. May, 1898, urine 38 ounces, sp. gr. 1011, urea 170 grains, a trace of albumin, only some epithelial cells found on microscopic examination. October, urine 52 ounces, 240 grains urea, no albumin. Has been much troubled with sleeplessness for past two years, for which he has taken morphia, one-half grain at night with the curious effect of producing sleep for three successive nights, and then a renewal of the drug being required. Has had *cupr. ars.* 2x and nitroglycerin 1 per cent. Went South in the fall of 1898, and has not yet returned. He reports, however, that he has not been quite so well, especially as regards strength.

1892.—Jas. McC., machinist, 40 years old. October 30th, examination of urine, quantity not stated, sp. gr. 1014, trace of albumin.

May, 1893.—Urine sp. gr. 1014, quantity not stated, albumin a trace. Headaches.

September, 1896.—Sixty-four ounces of urine, sp. gr. 1014, albumin of $\frac{1}{4}$ of 1 gramme per liter.

October, 1898.—Examination of heart showed second sound of aortic valves accentuated, left ventricle hypertrophied, dulness extending one-half an inch beyond the nipple line. Has had shortness of breath for past two months. Spells of dyspnoea at night, has to sit up in bed. This condition came on suddenly, being first noticed after a bicycle ride which was not very long nor very arduous. Urine 64 ounces, acid, sp. gr. 1016, urea 8 grains per ounce, a trace of albumin. This man was under my care prior to 1892 for several years, at least six, was ruddy and well nourished, and did hard work at his trade, but his urine was always of low specific gravity and contained a little albumin.

1895.—R. M. B., 48 years old, grocer. Examination of urine showed 80 ounces, acid, sp. gr. 1011, phosphates, no albumin. Irritable, nervous, sleepless, depressed, with frequent headaches, temporal arteries tortuous, radials like whipcords, apex beat of heart diffuse, soft systolic murmur at apex, heart enlarged, dulness to left of nipple line and below to 7th rib, some accentuation of pulmonic valve sounds, short breath. This man died a few months later—not under my care, however—was extremely ill for six weeks with various uræmic

symptoms. A post-mortem revealed contracted kidneys and a much enlarged heart.

Now regarding the matter of diagnosis. I feel that many of us through lack of routine examination of the urine often fail to detect the beginnings of Bright's disease. One cannot too strongly state the necessity of such routine examinations, particularly if there is the slightest doubt as to the diseased condition under consideration. I would further insist upon the need of testing the twenty-four hours urine, and of not depending on that of a single passage.

The presence of albumin in the urine does not by any means establish the existence of Bright's disease, neither does its absence indicate the reverse. It is only by a complete examination as to quantity, amount of solids, especially of urea, the presence or absence of albumin and sugar, and, most important of all, by the microscopic examination, that we can arrive at a correct estimation of the diseased condition. We should not forget that tube casts are destroyed by bacteria, and that we must preserve the urine submitted for examination by either a few drops of chloroform, by chloral or salicylic acid. As regards the tests for albumin, I have been greatly favored by obtaining the following complete notes from Dr. J. C. Guernsey:

TESTS FOR ALBUMIN.

In a suspected "Bright's disease" there is no factor that adds more to the comfort of the diagnostician than a delicate and easy, ready and reliable test for albumin. The journals so teem with purported tests that the average practitioner is sometimes at a loss what method to adopt in deciding whether there is any albumin present in the urine under examination.

Any one of the following *four* methods can be relied upon—with this proviso: If albumin fails to show with one test, try another test. The writer has known instances in his own practice and in the practice of some of his colleagues where albumin has failed to appear under the boiling and cold nitric acid tests, and yet the ferrocyanide test demonstrated its positive presence.

Also two absolute requisites to determine the presence of albumin are these: a. The urine **MUST** be acid in reaction; b. The urine **MUST** be clear. If not clear, filter; if filtering fails to

clear absolutely in connection with liquor potassæ, use the magnesian fluid. This will positively clarify the urine, but as it renders urine alkaline, it must be acidulated—or else use the acid contact method.

Boiling or Heat Test.—Boil suspected urine; if a cloudiness result, add a drop or two of nitric or acetic acid. If this acid clears away the cloud, there is no albumin. If cloud remains, albumin is present.

Nitric Magnesian Test.—This is more sensitive, acts more promptly, and gives a more sharply defined ring or “collar” than the nitric acid test. It is used in the same, contact, method, and is prepared by uniting one part of pure nitric acid with four parts of a filtered, saturated solution of magnesium sulphate; this does not stain the hands like nitric acid.

Ferrocyanide of Potassium.—This test avoids entirely all mucin. Fill test-tube two-thirds full, add a drachm of potassium-ferrocyanide solution (1–20), thoroughly mix, then shortly add fifteen (15) or twenty (20) drops of *glacial* acetic acid. If albumin is present this will cause it to appear.

Esbach's solution. In connection with Esbach's albuminometer one obtains an accurate test for albumin as well as the amount present.

In all cases of testing for albumin (except heat), if a cloudiness appears—apply heat. If the cloudiness remains in spite of the heat, this is confirmatory of albumin. If the cloud disappears, albumin is not present.

As regards the microscopic examination, the use of the centrifuge has rendered such tests very simple and speedy. A very few minutes' work enables us to acquire an exact knowledge of the condition of the kidneys as far as this means permits.

As a matter of course, the whole state of the patient is to be taken into consideration, and in Bright's disease the evidence presented by the heart and arteries is of the greatest importance.

Concerning prognosis I will say nothing.

Regarding treatment only a little; the subject is too large for this article. In acute nephritis, put patient into bed between blankets, in a warm room.

Employ warm baths, hot vapor baths or hot packs. Keep the

bowels soluble, preferably by some of the salines. Let water, especially distilled water, be freely drunk. The diet should consist largely of milk, fresh vegetables, fresh fruits and cereal foods.

In chronic diffuse nephritis a milk diet may be useful and tolerated for a short time, but patients do better for the longer time on a mixed diet. In all these cases of acute or chronic form, that particular individual's condition must be the guide, the amount of dropsy, the anæmia, the state of the heart, the season, etc., be all considered, and appropriate climatic, hygienic and medical treatment prescribed accordingly. Such phrases are very easy to thus express; we all know how extreme is the difficulty of suiting the "appropriate treatment" to the individual.

My experience with homœopathic remedies has not been great.

Aconite θ , 10 drops in 4 ounces of water, a spoonful once in two hours, showed its good effect in a case of acute nephritis, resulting probably from a cold.

I have used *cantharides* in drop doses several times daily, in the acute and chronic diffuse forms. It has been chiefly prescribed upon its pathological indications. It is, perhaps, the most important remedy we have for these two types. There is a growing opinion in the old school as to its value.

Cuprum arsen. 2x has been a most valuable medicine, particularly for uræmic conditions.

I have used it, however, more as a routine remedy in the sub-acute and chronic states of the disease under consideration, and I confess without accurate indications.

In *nitroglycerin* $\frac{1}{100}$ great reliance is to be placed, to relieve the conditions due to arterial contraction as found in the late stage of chronic diffuse nephritis and in chronic interstitial nephritis.

It is, besides, valuable in the uræmic dyspnœas and headaches of acute nephritis.

Gold, in the form of chloride of gold and sodium, I have used with good effects in chronic interstitial nephritis. Dr. Goodno advises its use particularly in the early stages of the disease. The dose has been 10 drops of a 1 per cent. solution in alcohol, repeated several times daily.

Mercurius corros. is, like cantharides, useful in the earlier stages of chronic diffuse nephritis before the period of contraction has set in.

Iodide of potash has been highly praised for its action in small doses upon the general process of arterio-sclerosis, and particularly as to the effect upon the kidneys.

The anæmia so commonly present in Bright's disease indicates the use of iron.

I have said but little about the treatment of chronic interstitial nephritis; my paper is already too long. I want a little space for the following remarks by Dr. John Nicholas Mitchell on the subject of Bright's disease of pregnancy, which he was good enough to put down for my use in this article:

In the first place I should like to divide the cases into three distinct classes, without at this time attempting any explanation of the causes of the disease.

CLASS I.—In this class I should place those rare and severe cases which occur immediately with or soon after impregnation occurs. In these cases the vomiting, insalivation and often severe headache are early symptoms, and very often spontaneous abortion occurs with relief of the kidney symptoms. If, however, the pregnancy continues, the vomiting increases, the patient becomes more and more anæmic, the kidneys secrete less and less urine, the quantity being reduced in two cases which I recall to some 3 ounces in the 24 hours. I have never found any medical treatment do these cases any good, and in my opinion the only thing to do is to produce an abortion, and this operation, if left undone for too long a time, becomes a very dangerous resort.

CLASS II.—In this class I place those which are most frequently encountered. In the seventh or eighth month albumin is found in the urine, later casts are discovered, and the quantity of urea diminishes. There may be œdema or not. In some of the most troublesome cases I have had there was none. If the disease is diagnosed at its inception, as it should be, if the attending physician makes a practice of frequent examination of the urine throughout the entire pregnancy, I have found it usually amenable to treatment, though, of course, some cases fail to respond to any medical treatment.

My main dependence has been upon the diet, all nitrogenous

food being eliminated, milk, vegetables and fruits being given. Living much in the open air is advisable. Hot baths with friction over the skin everywhere but upon the abdomen. Plenty of pure water given to drink. The medicine I have found most useful has been *merc. corr.* 2x to 3x. If at times uræmic symptoms appear I have given *cuprum ars.*, and if there was not a speedy relief, have supplemented these by a purgative. By these methods I have succeeded in many cases in carrying the patient through to term and delivering her in safety and without convulsions. Occasionally, one encounters cases where, notwithstanding the above treatment, the disease advances and the uræmic symptoms occur so frequently that it becomes one's duty to bring on premature labor. The only thing I have to say about this operation which would be appropriate to your purposes and request, is, that I have learned by experience never to bring on labor until by heavy sweatings and freest kind of purgings I have relieved the patient of all serum in the cellular tissue. I have seen deaths from serous apoplexy twice, and from pulmonary œdema several times, occur when this precaution has been overlooked.

CLASS III.—In this class I would refer to women who, suffering from chronic nephritis, become pregnant. At first thought this would seem a fearful condition of things, but in practice I have seen cases go through the whole pregnancy with seemingly no aggravation to the kidney trouble. I have learned, therefore, in such cases to treat them just as I do other cases, that is to watch for the symptoms of kidney failure, and if none such occurs to leave them alone; to watch their diet and the frequency of their outings, and only to bring on premature labor should the failing kidney and the uræmic symptoms call for such an operation.

LABYRINTHINE DISTURBANCES AND CONIUM.—Dr. Ord reports the case of a woman of 70 years, very robust, who was suddenly in the night, after having nursed her husband through a sickness of five months, with the consequent cares and night-watching, seized with attacks of vertigo, which were followed by a staggering gait, great difficulty of hearing, and severe headache, which was most pronounced in her neck and orbits. Her ears and Eustachian tubes were apparently normal. After taking *gels.* for eight days, which only relieved her vertigo somewhat, *conium* 1x was given, which was followed by amelioration of all the symptoms. The difficulty of hearing remained longest, yet this disappeared, and in three months she was wholly cured.

WHEN TO RUPTURE THE MEMBRANES.

BY EDWARD W. MERCER, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the County of Philadelphia.)

WE all know that in the vast majority of obstetrical cases there is no occasion for rupturing the membranes; that nature attends to this, and does it about at such time as they are no longer useful as a dilator of the cervix. While this is the rule, there are at times certain conditions, differences in the development of these tissues, etc., where, on the one hand, if they are illy developed, are too thin, there occurs a premature loss of the amniotic fluid, and as a result there may follow delayed or slow cervical dilatation.

On the other hand, there are cases where the membranes are dense and tough, and where they outlast their usefulness or are an impediment to labor; and it is a belief that we can do much in these cases towards shortening the first and second stage of labor, thereby lessening the attendant sufferings without any risk to our patients, that has led me to briefly present this subject for your consideration.

On account of the fact that in certain tedious and prolonged cases the accoucheur becomes restive, and is being constantly importuned to do something to relieve his patient, and that we all feel, at times, that anything that may cause a little change will be a relief, it is necessary for one to be very cautious about recommending the rupturing of the membranes, lest one should encourage the practice in unsuitable cases where the conditions will be made worse, and where simply a tedious case may be converted into one dangerous either to mother or child, or both.

I should say, before taking the step, before presuming to assist nature, *be sure you have absolute indications for doing so.* If in a given case the cervix is fully dilated, so that it is not distinguishable, or only as the merest rim, and the "bag of waters" extends well into the vagina and is impinging on the pelvic floor, it is certainly no longer of any use, and may be ruptured. But why do this? Because it is preventing the

head from descending, and thereby from flexing, that the most favorable diameters of the head may engage in the parturient canal. The expellant force is expended in attempting to drive the unflexed head through the pelvis, and is resisted by the tensile strength of the membranes, which is considerable. Another condition which calls for interference, I believe, is where there is a small quantity of amniotic fluid in front of the advancing head; where the dilatation has been partially accomplished but fails to be completed; the cervix is soft and dilatable, but an examination made during a "pain" reveals the fact that the examining finger may be readily passed around the head, between it and the cervix, indicating to us that the membranes are no longer exerting a dilating influence but may be ruptured with advantage, as this will allow the head to advance and press upon the cervix.

A somewhat similar condition is one in which there is absolutely no water made out under the membranes, but where they are stretched closely over the head. In these cases the dilatation goes forward very slowly or not at all, for the reason before stated that the head is unable to advance and flex on account of the resisting membranes, except as they stretch, which they do not readily do; hence there is very little dilating power exerted on the cervix. Frequently in these cases we are able to feel both fontanelles, showing the imperfect flexion present; and, where they are practically on the same level, I have repeatedly noticed a tendency for the occiput to rotate posteriorly, and have as frequently been gratified, after lacerating the membranes, to see the labor advance and the occiput from that time pursue its normal rotation toward the symphysis.

As the head descends in its partially flexed condition at the beginning of labor it soon meets the resisting membranes, which not only prevent its further advance, but by this counterforce or resistance being exerted on the occiput, the part which generally precedes, there is caused, if the pelvis is sufficiently spacious to accommodate it, an advance of the anterior portion of the head, in other words an extension, and consequently there is added to the resistance of the membranes the mechanical disadvantage of having longer diameters engaging in the lower uterine segment and pelvis. These extra resisting forces are frequently, I think I may say generally, sufficient to exhaust

the uterine muscle, and at the same time to wear the patient out to such an extent as to make her incapable of rendering the normal voluntary assistance at such time as it is needed. In these cases, when the membranes are ruptured, the occiput descends and becomes the dilator of the cervix; and, while it is not as efficient as the hydrostatic force exerted by a good "bag of waters," it is far superior to the head embarrassed by the unyielding membranes.

Some difficulty is experienced in determining whether or not the membranes are intact in this condition, but there should be little trouble if we can differentiate between their smooth surface and the hairy scalp.

In lacerating the membranes, the time-honored custom of using the finger-nail is not the one we would select to-day. Though we might not object to wearing a nail long enough and rough enough to use for this purpose, the effort made to rupture them will cause some pain or discomfort to the patient, and this may all be obviated by the use of the point of a scissor-blade or some similar instrument which has been sterilized. Where there is a large "bag of waters" it is no trouble to touch the membranes with the point of the instrument, and this is all that is necessary; but where they are drawn close over the head this must be more carefully done, on account of the danger of injury to the head beneath. One of the nicest things I find for this purpose is a tenaculum, or, as I generally use, one blade of the volsella forceps. It is passed into the vagina guarded by the finger, the hook being very gently drawn over the membranes, thereby lacerating them without the possibility of doing injury to the head, unless unnecessary force is used.

By this means, in such cases as I have indicated, I believe we can save hours of suffering, and at the same time preserve the patient's strength to such an extent as will make it far less frequently necessary to render instrumental assistance.

OPIMUM IN MENTAL DERANGEMENT.—Coma, loss of consciousness; rage, with strange or fixed fancies; the patient imagines that he is outside of his own body; frightful visions of mice, scorpions, etc.; *convulsive motions* and trembling; anguish, rage, inability to go to sleep, with bloated and flatulent abdomen; tendency of the blood to the head, with red face, etc.

THE POTASH SALTS—IN GENERAL.

BY WM. E. LEONARD, M.D., MINNEAPOLIS, MINN.

Professor of Materia Medica, University of Minnesota, Minneapolis.

(Read before the Minnesota State Homœopathic Institute, May 16, 1899.)

IN summing up the general action of this group of minerals, it is scientifically necessary to leave out the three Schuessler salts, because they are unproven, namely, kali muriaticum, kali phosphoricum and kali sulphuricum. Yet this is an unfortunate omission, for Schuessler has written down much concerning their action that is in strict harmony with what we positively know of the other kali salts. The persons who carefully prove these three will deserve an immortality like that of Hahnemann and his provers, for recent physiological medicine confirms their close relation to the higher nervous structures, *i.e.*, they are true "tissue remedies," because actual components of the living, growing human body.

The potash salts are far more poisonous than any of the alkaline group, *viz.*, soda, lime or magnesium, and more profound in their general action. Numerous fatal poisonings by the chlorate or chromate and nitrate (saltpetre) attest the power of potash as an irritant poison, capable, also, of changing the consistency, composition and color of the blood within a few hours.

1. All potash salts affect the *mucous surfaces* to produce increase of secretion, violent inflammation and deep eschars. Best known for this action are kali bich., causticum and kali bicarbonicum. Kali bichromicum shows this most clearly of all kali salts in Dr. Drysdale's chrome-workers' provings and its frequent clinical corroborations in chronic catarrhs. The surgical use of caustic potash—practically our causticum—confirms this usage; and its wide service in catarrhs, especially when accompanied by partial paralyses, is based upon reliable provings.

The chlorate of potash has long had empirical usage for acute catarrhal throat affections, a usage which, as truly

homœopathic when applied in minute doses, we are apt to overlook.

2. All potash salts affect the nervous system to cause paralyzes of both voluntary and involuntary muscles. Causticum and the bromide and—in toxicology a most notable instance—the ferrocyanide are the chief examples of this action.

3. All change the fluids of the body; when given in physiological doses, to bring about a profound anæmia, very difficult to treat, more persistent than that caused by any vegetable drug, as china, and resembling more in general that of arsenic, or a chronic dyscrasia. Kali bichromicum, bromatum, carbonicum and chloricum are best examples of this action.

4. Finally, it is, in general, true of the potash salts that there is in these three processes, *i.e.*, catarrhal, nervous and hematic, no inflammatory destruction of tissue, but rather a wasting by diminished functional activity; hence they are seldom indicated in acute febrile conditions.

CHRONIC PHARYNGITIS.

BY W. HOWARD LYLE, M.D., PHILADELPHIA.

(Read before the Trousseau Club, December, 1898.)

CHRONIC pharyngitis is the most common of throat diseases. Indeed, the throats of few adults are entirely free from this affection. No smoker escapes it, it is the bane of public speakers and singers, and no age or condition in life is exempt from its annoyances.

The causes are many, but they can all be summed up in one word, "irritation." This may be the result of extending disease of the nose, the inhalation of chemicals, dust or bad air, or from the improper use of the voice. It is, above all things, the result of mouth-breathing. Hypertrophy of Luschka's tonsil almost invariably leads to chronic pharyngeal inflammation. Patients with this disease seldom complain of many symptoms. With most of them it is simply a little burning or dryness in the throat, or there may be a pricking sensation, suggesting

the presence of a foreign body. There may be some mucous or even bloody expectoration, and there is apt to be constant hawking to clear the throat. The voice is often husky. These symptoms bear no constant relation to the extent of the disease. Frequently children with throats severely affected complain of no symptoms whatever. On the other hand, adults who suffer from all the discomforts we have mentioned, present little evidence of disease on inspection.

Examination usually shows a red, swollen, and more or less hypertrophied mucous membrane. On this thickened membrane we notice rounded, split-pea-sized elevations. These are enlarged follicles. They are reddish in color, and two or more may have coalesced. Enlarged veins may be seen which seem to terminate in these follicles. If the case is more advanced the inflammatory hyperplasia of connective tissue will have led to contraction, thus cutting off the circulation to such an extent as to cause atrophy of the mucous membrane. At this stage some of the follicles will have disappeared, while those which remain will appear even more prominent as they stand out on a background of dry, glazed, dull red, white-streaked membrane.

Until recently the study of the pathology of chronic pharyngitis has been neglected. It was taken for granted that these little elevations were due to hypertrophy of the closed follicles of the pharyngeal mucous membrane. Storek alone denied their glandular character, regarding them rather as swollen epithelial cells crowded against one another and deprived of their external protecting envelope. Recent post-mortem examinations have cleared up this subject, and Saalfeld (*Herying. Virchors Archiv*, Bd., 82, 1880) formulates the following conclusions: "The granules and the rugosities which project above the level of the mucous membrane, attaining sometimes the size of a pea, present a gelatiniform appearance, and are usually surrounded by a network of congested bloodvessels. The mucous membrane between them is but rarely hypertrophied, and is sometimes even atrophied. In examining these growths in the cadaver we may easily distinguish a little longitudinal cleft at the summit of each granule. This is visible especially in alcoholic specimens." Saalfeld claims to be the first to have discovered this detail. Microscopic examination

shows that the orifice of the excretory canal of the mucous glands is surrounded by a thick layer of swollen adenoid tissue. This layer is sometimes homogeneously infiltrated throughout the mucous tissues without forming round or oblong follicles. At other times we find, in addition to this diffuse layer, swollen follicles, where the stroma of the reticular tissue is more condensed. The orifices of the hypertrophied glands constitute at the same time the openings of the mucous glands. The epithelium which covers these growths is more or less atrophied, so as sometimes to leave only one or two layers of cells, or it may have disappeared entirely, in which case the granulation presents on its surface a loss of substance, the condition first noticed by Storck.

Although the vessels, and especially the veins, are dilated, their walls are normal. The red globules which distend them form a yellowish zone around the follicles, simulating an ecchymosis. These blood corpuscles are also found infiltrating the connective tissue and the interstices of the epithelial cells and the lymphatic cells, and are collected in quantity around the capillaries.

The diagnosis is easily made by inspection of the pharynx.

Prognosis involves not only the question of the continuance of the disease (which may be for months, or even years), but the danger of extension to the larynx, giving rise to changes in the voice, and even to complete aphonia. Moreover, it may go on to the incurable atrophic stage of the disease.

In the ordinary follicular form cure is not only possible but easy, provided the patient will follow directions. The persistent use of local applications is required, and in some cases a change of environment is necessary. Inveterate smokers must curtail their use of the weed, public speakers study to secure a method of voice-production which throws less strain on the pharynx, and all cases must have any gastro-intestinal disorder cured. The rare exudative form, while requiring great skill and care on the part of the attendant, can also be overcome; and only the atrophic form is incurable. Hygiene is important, and exercise, bathing and diet require strict attention.

Local treatment is in accordance with that of all catarrhal conditions. Cleanse the parts well with Dobell's solution. Use a Davidson atomizer to thoroughly cleanse the throat. Follow-

ing this, touch each follicle with the galvano-cautery. At times it is necessary to destroy the enlarged bloodvessels which run to the follicles and keep up the irritation. Destroy two or three follicles at a sitting, and repeat the treatment in about a week. This should be done until the hypertrophied follicles are a thing of the past. Sometimes it is possible to accomplish this by the use of astringents, though much more slowly. Use solutions of sulphate or chloride of zinc, 15 to 20 grains to the ounce of glycerin, or tannic acid in glycerin, iodine and glycerin, aqueous hydrastis, or compound tincture of benzoin. If local applications fail to relieve, we have recourse to the cautery. In the exudative form it is necessary to first curette the exudate from the follicles, and then apply nitrate of silver, either in strong solution or the stick. This destroys the follicles and leaves the pharynx in a healthy condition.

Internally, the following remedies are frequently useful: Hydrastis Canadensis, kali bichromicum, argentum nitricum, sanguinaria Canadensis, arsenicum iodatum, kali muriaticum, calcarea phosphorica and silica.

SEVEN CASES OF PREGNANCY COMPLICATED BY CHOREA.—Dr. Dakin has observed seven cases of chorea in pregnant women in the past six years, which go to confirm the accepted view that it chiefly affects primiparæ, and that a preceding chorea in childhood or an acute rheumatic affection predisposes to its breaking out in the first pregnancy. Six of the seven patients were under 25 years; five were married; in one of the two unmarried ones a fright had preceded the outbreak. The disease appeared in all during the first six months of pregnancy. In all, with one exception, a murmur was heard over the mitral valve; this latter was examined post-mortem, and revealed anatomical changes in that valve. Cases of chorea in pregnancy have not all a gloomy prognosis. The outlook is more dependent on the age of the patient than the pregnancy itself.

These patients were all greatly affected mentally, even maniacal, and in two there was actual insanity, which developed after delivery, while in three others it disappeared shortly afterwards. The choreic movements themselves are not quickly affected by emptying the uterus, and only in one severe case where it was done did they suddenly cease. In the others they were only a little less violent. In severe cases he regards artificial abortion as the most advisable measure. As long as pregnancy exists, remedies have but little action. Chloroform has only a transitory effect; hyoscin is more useful. Even though the movements be but slight, yet artificial abortion should be done as soon as the patient's mind begins to wander. As sudden elevations of temperature are dangerous, the temperature should be regularly taken, and hydratic measures be eventually used if necessary.—*Hospitalstidende*, No. 14, 1899.

EDITORIAL.

WM. H. BIGLER, A.M., M.D.

WM. W. VAN BAUN, M.D.

THE SCIENCE OF MEDICINE AND SCIENTIFIC MEDICINE.

WE are not of the number of those upon whom any criticism of Hahnemann or of Homœopathy acts like a red flag upon a bull. We think such thin-skinned sensitiveness is rather a mark of weakness than an exhibition of righteous wrath. So that when, in the June number of *Harper's Magazine*, in an otherwise clear and very interesting paper on "The Century's Progress in Scientific Medicine," we saw "Dr. Hahnemann" called "imaginative," and then referred to as a "masked pretender," we simply said, *Sancta simplicitas!* and continued fanning ourselves without any ebullition of feeling other than that caused by a temperature of 96° in the shade.

The paper is an exceedingly interesting one, both by reason of the orderly arrangement of well-known facts, and more especially because it affords proof that in the mind of the writer therapeutics has no part in scientific medicine. It is true that, had he attempted merely to catalogue the various theories and coal-tar practices which have marked the progress of "rational medicine" in the past century, the magazine would have been compelled to exclude all other matter. Had the writer been only tolerably acquainted with Hahnemann's work, or if he had only heard of his guiding principle, viz., that it was the whole duty of the physician to heal the sick, he would have been able to view the psora theory from a more logical standpoint, and would have seen that any reference to it in his paper was uncalled for. He has no word of condemnation nor of ridicule for "the physicians of the time who gave to the itch a fictitious importance by ascribing to its influence the existence of almost any obscure malady that came under their observation." Dr. Hahnemann, however, "who did not hesitate to affirm as a positive maxim that three-fourths of all the ills that flesh is heir to were in reality nothing but various

forms of *gale repereuteé* (suppressed itch)," is on that account called "imaginative" and a "masked pretender." Rather hard, this, on the sage of Coethen; but he doesn't mind it now, and we can stand even more with equanimity.

We do not approve of the attempts so often made to read into Hahnemann's writings meanings which they could by no possibility have had, even making the most liberal allowances for his extensive learning and philosophical mind; but any one, tired or otherwise, who has read his *Chronic Diseases*, will be convinced that in his psora theory he had more than the then common itch in mind. But even had he meant only the itch, even had he fought as obstinately against a parasitic origin of the disease as we are told, in the paper, many of those in the ranks of acknowledged scientists did, it would not detract in the least from the value of his work. Although he lavishly poured out words to explain and elaborate his theories, he always had enough remaining to found his practical system. His theories were all practical, and were at once applied according to the governing law of homœopathic therapeutics. They were no idle vaporings of a dreamer, but the results of close observation by a practical physician. They never, in themselves, formed the independent basis of practice, but were all made subservient to the law of *similia*, which alone was set up as the guide in healing the sick. Hence, no matter whether or in how far his theories may prove to be incorrect, his system of therapeutics is alone a proper object of attack. His position and merits are to be judged according to the claims which he himself sets up for them. He started from the principle that the sole duty of the physician, as physician, is the healing of the sick, quickly, safely and pleasantly. For this he wrote; for this he worked. It is, therefore, not only foolish, but unjust, to compare his work with that of those who have merely attempted to advance scientific medicine apart from therapeutics. We often hear and read it advanced as a reproach against homœopathy that it has contributed nothing to the advance of medical science. We can justly and proudly point to the advances in the science of therapeutics which are due, directly or indirectly, to the teachings of Hahnemann and his followers. Besides the passive influence which has made itself felt in the almost complete revolution of the traditional practices of the

"old school," the discoveries of new remedial agents, and of new applications of old remedies, all based upon law, and not upon ephemeral theories and unthinking empiricism, surely sufficiently refute such a charge of inactivity and inefficiency.

Homœopathy claims to be the Science of Therapeutics, and its claims are to be substantiated by all scientific means possible; but we are not to be led astray from the standpoint of its founder in an attempt to cater to a demand for more of pure scientific medicine. Let us have as much science as possible, let our students be as scientifically educated as possible, let us contribute as much as in us lies to the advance of scientific medicine, but let us never lose sight of the fact that to us, as physicians, these things are only means to an end; that the cure of the sick is our paramount duty, and that therein lies the true science of medicine.

We may individually be better fitted for the cultivation of pure science than for the practical application of its results, or *vice versa*; but, in either case, let us fully recognize our position, not failing at the same time to appreciate the value of the labors of those whose mental constitution differs from our own.

SMALL-POX.

THE simultaneous occurrence of small-pox in almost every section of the United States is a condition which may well cause apprehension. With the advances made in sanitary science, and the increased experience gained in later years by the State and local Boards of Health, there is a possibility that the efforts to stamp out the loathsome disease before the weather conditions become more favorable for its spread may prove successful. We have no doubt that the present prevalence of the disease is due in a great measure to the failure of attending physicians to recognize their cases and properly to isolate them. It behooves all physicians, therefore, to make themselves familiar with the symptoms which should excite their suspicion. There are, of course, many physicians of the present time, and some of them by no means neophytes in the practice of medicine, who have never seen a case of variola,

and it is not to be wondered at if, lulled into a fancied security, based upon the compulsory vaccination laws in many communities, the first cases presenting should have been regarded as varicella or measles.

Those of us who passed through the epidemic of the early 70's can well remember our confusion at first, and our unwillingness to recognize its widespread character; but, no doubt, equally vivid is our recollection of the change which came over the spirit of our dreams, and how, in a very short time, we came to expect hardly anything else when called to a patient for the first time. If we call to mind the very loose way in which isolation and quarantine were carried out we can only wonder that the epidemic was not more extended than it actually was. We of the homœopathic school, in the light of experience gained then, can see how many incorrect observations were made, and how many unjustifiable conclusions drawn, in consequence of the desire to let no case escape unrecognized. Then every severe backache was the prodrome of variola, and the number of remedies found capable of aborting small-pox waxed exceeding great. This is and always will be the case in an epidemic of any disease. Cases of doubtful diagnosis will always at first be classed with the prevailing sickness, and Science may be considered fortunate if she is not compelled to revise her documents, and insert many anomalous and exceptional forms of disease, fitted into the Procrustean bed of an erroneous diagnosis, by the neglecting of some characteristic symptoms, and by the exaggerating of others.

In the beginning of an epidemic of an unfamiliar disease the typical symptoms which would lead us to suspect its presence are all that are necessary to be kept in mind; later sober study will enable us to diagnose doubtful cases. There have been various presentations of these symptoms in the case of small-pox, and these should be constantly before our minds until the danger of an epidemic is past. The characteristic severity of the constitutional prodromal symptoms, the high fever and the intense backache; the macular then papular eruption, with its shotty feel, on the third or fourth day, with a fall of temperature; the change into a distinctly umbilicated vesicle by the fifth or sixth day; the rise of temperature in the secondary fever, as the vesicles change into pustules, by the eighth day;

and, finally, the formation of scabs by the drying up of the pustules, are the salient points of diagnosis.

The diseases with which variola has most frequently been confounded are measles and chicken-pox. In the former, the catarrhal prodromes, the persistency of the macular character of the eruption, together with the presence of Koplic's sign of minute bluish-white spots on the buccal mucous membrane, should be in most cases distinctive. In the latter, the absence of the peculiar shotty feel of the papules, of the umbilication, until produced by the beginning of desiccation, and of the secondary fever, together with the fact that the eruption, coming out in crops, presents at one and the same time different stages of its development on different parts of the body, are circumstances which in all but exceptional cases prevent mistake.

That mistakes may be made even by the most careful must be acknowledged, but that as many should have happened as have been reported is not creditable to the profession.

THE FIFTY-FIFTH ANNUAL MEETING OF THE AMERICAN INSTITUTE OF HOMŒOPATHY.

THE Atlantic City meeting of the Institute was a more phenomenal success than its most ardent advocates dared anticipate. The attendance reached a new high-water mark, with five hundred and fifteen members, and twelve hundred visitors, or a total of over seventeen hundred present. Two hundred and twenty new members were added. The weather was ideal, being clear and cool. All the sessions were favored with large audiences, the popular sections being crowded, the papers calling forth animated and interesting discussions.

The shortened session was an unqualified success. The large majority of the members, remaining through the whole five days, aroused and sustained an enthusiastic interest to the very end, which was in pleasing contrast to that of the last few meetings held with an intervening Sunday, where a corporal's guard could hardly be mustered for Monday and Tuesday's sessions. The one great drawback was the noise outside and in the rear of the assembly halls. Two-thirds of this was

absolutely due to the members themselves, who thoughtlessly but very naturally stopped to chat, and talk, and laugh with old friends. This was good in its way, for friendship is too precious not to be prized, but it was fatal to a full and complete success for the sectional meetings. The indefatigable Local Committee—all honor to its effort—did its utmost to overcome this difficulty. But the members refused to be controlled in this particular, and in this only did the Local Committee fail in its undertakings. In all things else it was rewarded with magnificent success, for which the Institute was deeply grateful and appreciative. The social side of the meeting was also a record breaker, and the person who was not satisfactorily entertained could not possibly be pleased. For an extended account of the meeting the reader is referred to the *News* pages of this number.

PUERPERAL INFECTION (Rosenberg).—Puerperal infection may be due to more than one specific micro-organism, and not to streptococci only, as has been thought. The streptococci, bacillus fetidus, bacterium coli, gonococci, pneumococci, diphtheria bacilli and the bacterium of putrefaction have all been known to cause puerperal infection. Some of these pathogenic microbes are not infrequent inhabitants of the vagina of apparently healthy individuals. The normal secretion of the vagina has a whitish color, the consistency of curdled milk, is mingled with mucus, and has an intensely acid reaction. The pathological secretion has a yellowish color, usually an acid reaction, but it may be neutral or alkaline. The normal secretion contains only the bacillus vaginæ, which cause the acid reaction and prevent the growth of pathogenic bacteria. The pathological secretion contains pathogenic bacteria or cocci, and not the bacillus vaginæ. The genital canal is divided into two parts, one infected, the other sterile. The former comprises the vestibule, the vagina and the lower portion of the cervical canal. The latter consists of the upper part of the cervical canal, the uterine cavity and the tubes. The human organism is well capable of combating these bacteria, provided the normal functions are not disturbed and the vitality of the tissues is not lowered by useless manipulations and interference. Experiments have demonstrated the fact that if disinfecting douches were administered the infecting microbes were not destroyed by the douche, but it took the vaginal secretions from nineteen to thirty-six hours to destroy microbes that without the douche would disappear in from eleven to twenty-four hours. Puerperal infection, in the vast majority of cases, is due to the introduction of infectious material into the woman's system through unclean hands and instruments. The use of the various antitoxic serums has been successful in rare cases, but a more extended use has not been satisfactory. Soluble silver salts have been recommended, but the cases reported are too few to permit any definite conclusion.—*American Journal of Obstetrics*, March, 1899.

GLEANINGS.

CERTAIN FORMS OF LATENT MALARIA IN CHILDREN.—Dr. Johan Cronquist, in a study of malaria in children, mentions certain varieties which may be manifestations of a latent malarial infection.

1. *Intermittent Hæmorrhages.*—Prof. Filatoff describes two cases of intermittent nose-bleed which appeared periodically in children of 7 and 12 years, which set in at a certain hour of the night, and which was cured by quinine.

Still others have noted such cases.

2. *Intermittent Diarrhœa.*—Prof. Filatoff, of Moscow, also records three cases of chronic intermittent diarrhœa with an afebrile course in children of 5 to 10 years. The evacuations were of mucus and blood, and often associated with colic and tenesmus. They would appear either the same time every day or every other day, or be especially pronounced at a certain time of the day. At other times or hours there would be either no evacuations or normal ones. The general condition would be very good in spite of the diseases having persisted for several months. In one of the cases the spleen was not enlarged. Cronquist has also observed such a case.

3. *Intermittent attacks of a short, dry cough* has been noted by Filatoff in a girl of 3 and a boy of 8 years, which cough would appear at the same hour every night, while neither the larynx nor the thorax revealed anything abnormal. Only in one was there an enlarged spleen, with fever in the beginning, which latter soon disappeared. Both were cured by quinine.

4. *Intermittent Skin Affections.*—Boicesco and Moncorvo set forth an erythema nodosum of palustral origin in children. There are reddish-yellow or red round or oval nodes and plaques, which appear in the skin, and rise slightly above its surface. The extensor surfaces of the forearms, legs, forehead, temples and malleolar regions are chiefly affected. The efflorescences augment in size periodically, become sensitive, and scale off. They persist for two to six weeks. The affected spots itch.

5. *Intermittent Neuralgias.*—Filatoff records two cases, one in a boy of 5 and the other in a girl of 11, who suffered from periodic pains in the stomach, localized in the epigastrium and the umbilicus, which were accompanied by an enlarged spleen, without fever, and were removed by quinine. Bohn asserts that malaria causes disturbances of the fifth cranial nerve, especially its temporal and supraorbital branches. Often the headache of older children, on closer examination, will be found to consist of an unilateral headache. He has seen thirteen cases in children from 1½ to 12 years, usually over 5 years. The pain would generally come on every other day, and be localized in different nerves. Intermittent or continuous headache may be the only sign of latent malarial infection. In one of Filatoff's cases the headache would appear every day at two o'clock in the afternoon. Quotidian intermittent

fever had preceded. The author has also seen such a one.—*Nordiskt Medicinskt Arkiv*, Hft. I., Bd. X., N. F., 1899.

HEREDITARY SYPHILIS WITH REINFECTION.—Dr. Jullien observed a young man of 22, an abortive specimen of manhood, whose father married five months after having contracted syphilis. He offered numerous hereditary dystrophies, for his mind was extremely feeble, his skin was discolored, covered with cicatrices, and as if atrophic, while there was a congenital absence of nails, their place being taken by small and depressed grooves of a fibrous appearance and furrowed longitudinally. His eyes, frequently diseased, were incessantly lachrymating; his tongue presented signs of superficial sclerous glossitis, with a psoriasiform covering and bleeding fissures. Besides, he was hemophilic to such a degree that he had nearly bled to death several times from ordinary epistaxis.

He had had connection with a syphilitic woman, and a month later an infecting chancre (hard) developed; then, in three months, the secondary symptoms set in. It was at this time that he was examined. There were discrete syphilides on his trunk, which were very confluent on his scalp, forehead and legs, where they were papulo-pustular and of an ecchymotic aspect. His general condition was greatly reduced, and mercury he could not tolerate; for every time that he took it he suffered from a hæmorrhagic gingivitis. Three days after the examination he succumbed to a pneumonia.—*La Semaine Medicale*, No. 17, 1899.

A MELANODERMIC ERUPTION OF THE PENIS DUE TO ANTIPYRIN.—Prof. A. Fournier, of Paris, reports two cases where, after ingestion of antipyrin, a singular eruption appeared on the penis, which was somewhat alarming.

The first, a diabetic, came to him with the idea that he had a gangrene of the penis. This organ was swollen and infiltrated at its extremity, so that it resembled a bell-clapper. The prepuce and glans were swollen, red, and covered with large patches of a very dark raspberry color. As to pain, he experienced only a little formication; there was complete apyrexia; his general condition was excellent; therefore there could be no thought of gangrenous phenomena. The patient related that the day before, at midday, suffering from headache, he had taken antipyrin. At half-past four he had felt a prickling in his glans penis, and soon after these blackish spots appeared which had so frightened him. But the eruption was not localized in this spot alone, for there were other plaques on the external sides of both ankles and in one interdigital space.

The second patient also came to him very much worried over blackish spots which had suddenly appeared on the extremity of his penis. There was neither heat, redness nor swelling. He also was a habitual user of antipyrin, but he had never experienced any trouble from it before. In the first case the blackish spots had persisted for five or six weeks.—*Ibidem*.

INDICANURIA IN TYPHOID AND SIMPLE FEVERS.—Dr. A. Motta-Coco states that, in general, in typhoid fever, indican is not eliminated in goodly quantities until the third week of the disease, and particularly during the fourth one, and in convalescence, when the patient is placed on a heavier diet. In the so-called febriculas, the simple fevers, indicanuria is usually pro-

nounced *from the very beginning*, and in the days of the second week increased quantities are excreted. Therefore, during the first few days of an indefinite febrile process, when typhoid is suspected, if quite a quantity of indican be eliminated typhoid fever is probably *not present*, though from this it cannot be asserted absolutely to be absent. However, this sign is of value in differentiating.—*La Settimana Medica*, No. 14, 1899.

A FEW NOTES ON THE TREATMENT OF CHLOROSIS.—Dr. Dunin, of Warsaw, explains failures with treatment of this disease with iron by mistakes in diagnosis. In true chlorosis iron acts as a specific, but not in pseudo-chlorosis. He employs always Bland's pills, sometimes associated with arsenic, and in spite of any stomach symptoms which may be present. Treatment must be continued for a long time; for example, six months; and, after termination of the regular treatment, one should take iron ten days in each successive month, for chlorosis is a disease which is exquisitely relapsing. Rest in bed is of the greatest importance, for it is a grave mistake to recommend exercise to chlorotics, for that will only delay recovery. A trip to the mountains is usually badly tolerated by these subjects, and with cold water one cannot be cautious enough. Alcoholic drinks should be wholly left alone; tea and coffee, at first, entirely forbidden; later, to be restricted decidedly.—*Berliner Klinische Wochenschrift*, No. 14, 1899.

OREXIN BASICUM IN VOMITING IN PREGNANCY.—Dr. Hermanni gives 30 cgms. of this drug, three times a day, in vomiting in pregnancy, with good results. It is administered in capsules.—*Norsk Magazin for Lægevidenskab*, No. 4, 1899.

AN INTERESTING CASE OF LATE HEREDITARY SYPHILIS OF THE BONES.—Dr. Donner, of Stuttgart, was consulted by a student of medicine, 21 years of age, in 1890, on account of a bilateral inflammation of the ankle-joints. He had been treated by different teachers at the University for two years with salves of iodine, ichthyol, compressive and plaster bandages, etc., but, unfortunately, with negative results. He could no longer walk, was bedridden, and greatly reduced by pain. Although he had no faith in homœopathy, yet, as various prominent allopaths had been able to do nothing for him, he had decided to try it; for a prominent Wurtembergian surgeon, after vainly injecting iodoform into one ankle-joint, had advised amputation of his left leg in order to prevent general infection of his system. When seen, the external and internal malleoli of both legs were greatly enlarged, and the left foot, both internally and externally, necrotic. Several bones of the ankle-joint were hyperostotic in both feet, while on the left there was necrosis in the foot, apparently originating in the talus. Anamnestically nothing could be learned of his parents; on the contrary, he related that in his earlier years he had had an interstitial keratitis and a perforation of one drum-head. Since his sixth year he had suffered from a nasal catarrh, which, as discovered, had led to a little perforation of the septum narium. Besides these, he had a squamous syphilide of the left ear. His teeth were all carious, and there was a terrific fetor of the breath. On account of the serious nature of the necrosis he received merc. precipitat. ruber 3, kali iod. and stillingia 3. He was left in ignorance of the diagnosis. The action was actually striking. In four weeks there was not a drop of pus to be noticed, the pains had vanished, and

in four months the hyperostoses had so decreased that he was able to take walks of one and a half to two hours' duration. These results made such an impression on his mind that he promised to take up homœopathy. He returned to his studies at the University, and was not heard of since. Possibly he practices now somewhere, and laughs and sneers, in chorus with his colleagues, at homœopathy, to which he owes not only his foot, but even his life itself.—*Ueber Spaetformen von Angeborener Syphilis*. Syphilis congenita tarda, Stuttgart. (This case is taken from a very thorough little work by a homœopath of Stuttgart, Germany, Dr. Donner, which ought to be read and re-read by every homœopath. It is, unfortunately, not translated into English.)

TREATMENT OF FURUNCULOSIS BY BREWER'S YEAST.—Dr. Brocq, of Paris, the well-known dermatologist, is an earnest advocate for the treatment of furunculosis with brewer's yeast. He first describes his own case, which had bothered him for years, and which was cured by the internal use of brewer's yeast, a teaspoonful twice a day. In three or four days the painfulness had disappeared, in four or five the inflammatory symptoms and the suppuration had vanished, and on the seventh or eighth day they wholly disappeared, and the boils cicatrized, leaving indurations, which remained as long as with any other treatment. Amongst the fifty other patients which he treated thus there were some who for years had suffered from furunculosis, and who were rapidly and finally freed from their affliction by this simple remedy—brewer's yeast. Fresh yeast had best be obtained every day, and shaken up in a glass of ordinary or mineral water, or even beer. In case of necessity, baker's yeast may also be employed, taking a piece as big as a hazel-nut at each meal, dissolved in water. In general, the dose may be varied according to the tolerance of the patient and the degree of the disease—from three to nine teaspoonfuls daily. It is to be noted that there is a great difference in the activity of the different kinds of yeast, and that at times slight gastric disturbances, as eructations and diarrhœa, may be noted. In order to prevent recurrences, one should continue with the treatment as long as there is any inflammation or pronounced induration. Also in extensive acne, folliculitis, and certain forms of sycosis. Brocq has obtained good results, though not as surprising ones as in furunculosis. He does not praise it as a specific, as quinine is in malaria or hydrargyrum in syphilis; but it is very agreeable, and renders operative measures and complicated dressings unnecessary.—*Wiener Medizinische Presse*, No. 17, 1899.

MERCURY IN GONORRHOËAL GENERAL INFECTION.—Dr. Böttcher reports a case of general gonorrhœal infection, multiple gonorrhœal arthritis, and metastatic conjunctivitis, where treatment by mercury yielded immediate and brilliant results. In seventeen days there was a decided retrogression of the joint affection, and in six weeks the articulations were wholly free from pain.—*Berliner Klinische Wochenschrift*, No. 17, 1899.

OVARIAN CYSTOMA AS A HINDRANCE TO LABOR.—Dr. Nash, in a sex-tipara, found, on examination, an elastic and fluctuating tumor, which was situated between the uterus and rectum. This prevented the descent of the head, and had brought about a prolapse of the umbilical cord. No pulsation could be detected in the cord. He diagnosed a cystoma of the ovary, and punctured it through the vagina. The forceps were then applied, and a dead child extracted.—*Ibidem*.

FRANK H. PRITCHARD, M.D.

THE MANAGEMENT OF TUBERCULOUS SINUSES, ABSCESES AND FOCI.—V. P. Gibney, M.D., says: In going over the histories of my cases I find very many illustrating points in the management, but I shall refrain from reporting the same, believing that I have already occupied your time sufficiently long.

A number of years ago, at the hospital, we evacuated abscesses for an entire year, injecting iodoform in oil or glycerin, and failed to get results sufficiently satisfactory to warrant us in continuing the practice. We were all disappointed. Then, for two or three years, we aspirated without cleansing the sac, but simply strapping immediately after aspiration. At least 50 per cent. were cured after a few aspirations; a number were relieved after two or three aspirations. It has become, therefore, the practice of the hospital to aspirate whenever the abscess appears, but to *inject nothing* into the sac. In my private practice I invariably aspirate, and assure my patients that a few repetitions will effect a cure. It is seldom that I am disappointed. Occasionally the puncture leaks a little, becomes enlarged by means of the pressure within the sac, and then I simply dress the parts aseptically, and closure soon follows.

While I come in contact, from time to time, with surgeons who speak slightly of aspiration, and who think that no good results follow, I have no hesitation in making this assertion. It is one of the best means within my knowledge of treating the ordinary cold abscess of tuberculous disease. I have had no reason for many years to change this conviction. It is a simple process, does not require an anæsthetic, the skin can be frozen with ethyl chloride, and the operation is practically painless. If one fails to get pus, the attempt can be made later; but for the general practitioner I know nothing that is better suited to his wants if he encounters many abscesses like those under discussion.

By employing ethyl chloride as a local anæsthetic, or laughing-gas for simple narcosis, a small opening may be made over most any abscess sac, the contents evacuated, and the parts hermetically sealed. The employment of an ice-bag immediately afterward will allay any inflammatory conditions that may threaten. I have been very much pleased with this method.

With regard to sinuses, I am convinced that a thorough dissection of the lining membrane is necessary to effect a cure. Of course, there are instances where it is impossible; then a curette may be employed, except in the abdominal cavity. For thorough dissection or thorough curettage I simply flush out well with sterile water, then mop the parts well with a pad of iodoform on a director. The next step is to wash out thoroughly with the peroxide of hydrogen, and finally dry the track. I seldom employ any tenting or tubes. It is just as well, if one is satisfied that the parts are thoroughly cleansed, to employ a sterile pad of gauze, and take chances on any discharge. In resorting to this method, where such focus is found, I invariably attempt its removal. It is often not necessary to do an excision, but merely to do a thorough evident or cutting away of the soft bone until the hard bone is encountered. Let this be the bottom of the sinus or track. After a thorough operation of this kind, I usually employ a plaster-of-Paris dressing for fixation. The parts are not disturbed for awhile, sometimes a week or ten days. I usually wait for some indication, such as a rise of temperature or staining of

the dressing. I have long since satisfied myself that the use of peroxide of hydrogen for sinuses is futile. The injection of bichloride of mercury or any chemicals is practically useless. We must bear in mind always that we have tuberculous tissue to deal with, and, if possible, this must be removed.

Where the foci are numerous and close together, as in the head and neck and trochanter of the femur, nothing short of a radical excision will suffice. It must be borne in mind, however, that these foci must be recognized or one must be convinced that they exist before resorting to operation on a child in good condition. Early incisions, while they yield more brilliant results, are not looked upon with favor by the majority of surgeons—at least by the orthopaedic surgeons—and we leave these operations until a later period. Just when to interfere of course is a difficult question to decide. By attention to sinuses, to small foci, and to abscesses, above all things, by protection to the joint or bone diseased, excision will seldom become necessary. Where these operations fail, and where the patient is losing ground, it is best not to wait until too much ground is lost, but to interfere promptly, and let the patient have the benefit of the doubt.—*Virginia Medical Semi-Monthly.*

WALTER S. BRIERLY, M.D.

ELECTRICITY IN MALPOSITION OF THE UTERUS (Martin).—Simple retroversion is treated by general tonics and hot water (115° F.) douches of one drachm of alum to the pint, in a recumbent position, twice a day, and not less than a gallon at a time. The patient loosens her clothing four times a day and takes the knee chest position two minutes at a time. The muscles of the pelvis are toned by exercising them with a slow, interrupted (not more than two vibrations in a second) faradic or sinusoidal current once daily, or at least every second day, ten minutes at each time.

A non-developed uterus is treated with much success by a bipolar intra-uterine electrode passed up to the fundus and the current gradually turned on, according to the tolerance of the patient, for five or ten minutes at a time.

TAMPONS AND PESSARIES IN THE UTERUS (Watkins).—Fine sterilized lamb's wool is the best material for tampons, which should be used almost continuously. It is useless for a patient to wear tampons for one or two days and then go equally long without them. They are best inserted in knee chest, knee elbow, or in Sims' position. Pessaries must be fitted carefully to each individual case. A pessary never should be used when there are present any sensitive points which it will press upon, or when the uterus has a marked tendency to return to the abnormal position as soon as it is replaced. The pessary should be removed at once if it produces any pain or discomfort. It should be removed every two to three months for cleansing and readjustment. Douches are not necessary except for cleanliness. A patient with a retroposition of the uterus, who is made perfectly comfortable by using a pessary, will enjoy much better health by continually wearing the instrument than she will as a result of any of the operations of fixation and suspension yet devised.—*Am. Gyn. and Obstet. Journ.*, March, 1899.

THE RELATIONS OF PELVIC CELLULITIS TO RECENT PELVIC SURGERY (Van de Warker).—The following is a synopsis of the more important symptoms between pelvic peritonitis and pelvic cellulitis :

PELVIC PERITONITIS.

Following labor or abortion in a few days.

Beginning in a rigor.

Severe fever, face pinched, prostration.

Pain acute, sharp.

Great tenderness of abdomen.

Tumor usually behind pubis.

Tumor, as a rule, not above pelvic brim.

In early stage more evident in vaginal cul-de-sac.

Suppuration rare.

Purulent pelvic peritonitis attended with symptoms of peritonitis.

Purulent mass intra-abdominal.

Pus confined.

Pus tends toward viscera or is encysted.

No retraction of thigh.

When mass extends into the iliac fossa it is not well defined.

Tumor elastic or fluctuating.

Always uterine displacement with peritoneal mass.

Never involves abdominal wall.

Relapses from slight causes frequent.

Sometimes an intestinal percussion note over mass.

Never extends to vaginal wall.

Often associated with specific infection of vagina.

Occurring without lesion of genitalia.

Pain always intra-pelvic.

Phlebitis not observed.

PELVIC CELLULITIS.

Eighteen to twenty days after.

No rigor.

Less fever, no facial or general reaction.

Pain dull, throbbing, like beginning abscess.

Lesser tenderness.

Tumor usually in iliac fossa.

Tumor at or above brim.

In early stage less evident in cul-de-sac.

Suppuration very frequent in phlegmons (Bernutz).

No symptoms of peritonitis.

Purulent mass in iliac fossa, sub-peritoneal.

Pus often diffused and burrowing.

Pus tends toward abdominal wall or deep iliac fossa.

Retraction of thigh.

In cellulitis always well defined.

Tumor more solid.

May be absent with very large pelvic mass.

Often involves abdominal wall.

Relapses rare.

Dull on percussion.

Extension of cellulitis from broad ligament or iliac fossa into vaginal wall.

Usually no specific infection.

Often following lesion.

In addition, pain in anterior and inner side of thigh to leg and foot.

Phlebitis an occasional complaint.

There is not a single fact at present to prove that the uterus is a superfluous organ after castration. The idea is a product of the French method of vaginal hysterectomy for pelvic inflammation. The improved results was due to the efficient drainage along the clamps and forceps left *in situ* from the inflamed cellular spaces and non-absorbed exudate. The hysterectomy was not essential to cure; it was simply a method of drainage. An intra-peritoneal abscess drains badly, and special measures are necessary for drainage and thorough toilet. The cellular abscess can be opened at the most available point. It drains well, owing to the contractility of its environment, and there is less tendency to diffusion and general sepsis than in the former. A persistent pain of a throbbing, wearing character, attended by hectic and progressive anæmia, attends the suppurating phlegmon in its mature form, and calls imperatively for operation.

From a surgical standpoint the most important difference between the

intra-peritoneal abscess and the suppurating phlegmon is the plastic exudate circumscribing the former and tending to localize the collection. The phlegmon has no such exudate, and the mass is not the result of adhesive inflammation in near parts, but the product of homogeneous tissue. The mass forms first and the pus collects later in the centre, and migrates along channels of the least resistance. The best way to follow such a sinus is with the finger, using finger-nail dissection in straightening the channel and breaking up septa. Drainage with a rubber tube, and avoiding the use of carbolic acid, corrosive sublimate, formalin and peroxide of hydrogen, usually will cure such sinuses in from one to three months. Cœliotomy is not advisable for cellular abscesses. Drainage of the peritonæum through the vagina requires direct opening of the sac, leaving the track into the cellular exudate separate from that leading into the peritonæum. Drainage of the peritonæum rarely requires more than two or three days, while cellular drainage may require as many weeks. An incision in the anterior vaginal *cul-de-sac* is better for penetrating toward the iliac fossa than the posterior *cul-de-sac*.

Abscesses having a long, fistulous tract opening external to the sphincter ani are apt to be situated in the deep iliac fossa, and are best treated by dilatation and drainage with irrigation, provided the foci of the abscess may be reached. Gauze is not so good for drainage as rubber tubing.

Pelvic cellular abscess breaking through the bladder or rectum is inaccessible to treatment in that location and requires counter-openings. Rectal openings are more serious than those which open into the bladder, besides the danger of pus absorption from the rectal surface, and of mixed infection from intestinal gas entering the abscess cavity. Counter-openings in these cases are urgently indicated, either supra-pubic or vaginal. Thorough dilatation of the sphincter ani and douching of the rectum are very necessary.—*Am. Gyn. and Obstet. Journ.*, No. 3, 1899.

THE DIAGNOSIS OF GONORRHOEA IN THE FEMALE.—Bröse and Schiller made a careful examination of two hundred and seventy-one cases and about fifteen hundred microscopical preparations for gonococci. The examination of the secretions of the urethra, Ekern's lacunæ, Bartholini's glands, the vagina and cervix, requires a great deal of time if thoroughly done. The best method of coloring is Pick-Jacobson's. Experiments in chronic urethritis and cervical catarrh by irritation with 10-20 per cent. solutions of nitrate of silver and 50 per cent. of chloride of zinc to develop latent gonorrhœa out of the tissues were practically without result. Gonococci were always found in acute gonorrhœa in the female, but the proof of the gonococci is not, as a rule, necessary for the diagnosis of gonorrhœa. Urethritis is the chief symptom, and it is almost always gonorrhœa. The rare cases, non-gonorrhœal, of purulent urethritis, are recognized by their rapid course. The combination of acute diseases of various parts of the female, as vulvitis and urethritis, urethritis and cervical catarrh, urethritis and vaginitis, urethritis, cervical catarrh and diseased adnexa, especially favors the diagnosis of gonorrhœa. Difficulty may occur in those rare cases where the cervix only is diseased without infection of the urethra, and here a microscopical preparation may be the only means of determining a diagnosis. Neisser's dictum that in all chronic cases of gonorrhœa in the female the diagnosis can only be made by the proof of the pres-

ence of the gonococci is not correct, and may lead to mistaken diagnosis in many cases. The diagnosis of chronic gonorrhœa in the female is based, before all else, on the presence of disease at the same time in different parts of the genital tract. Chronic urethritis is the surest sign of chronic gonorrhœa. The other affections of the vestibule and vagina above are uncertain, but if combined with disease of the uterus or tubes are pathognomic of gonorrhœa. The combined occurrence of uterine catarrh and inflammation of the adnexa point usually to gonorrhœa. Positive as is the presence of the gonococci in diagnosing gonorrhœa, the absence of them is not equally negative. The main dependence of diagnosis must rest on the clinical symptoms.—*Berliner Klin. Wochenschrift*, Nos. 26-29, 1898.

A METHOD OF PREPARING CATGUT (Hirst).—The cumol gut is very satisfactory in some respects, but does not last long enough, and chromicized gut lasts too long. Even boiling in alcohol at 240° F. does not necessarily sterilize catgut. The following method has been very satisfactory: The catgut is soaked in benzine twelve hours to remove the fat. It is then dried on blotting-paper and soaked in sterile water to make it receptive and absorptive, after which it is immersed in a five per cent. solution of formalin over night, about fourteen hours. It is then washed, to remove the excess of formalin, and stretched on a form, such as Edebohls uses for chromicized gut, and is allowed to dry four or five days in a well-heated room till absolutely dry. It is then wound on a conveniently large wooden spool, so that the coils will not cross each other, and is finally put in a ten per cent. solution of glycerin in absolute alcohol. It is then sterilized for from forty-five minutes to an hour in a metal cylinder with a tight screw cap, which is put in an autoclave sterilizer and kept at 240° F. In this way the catgut is made absolutely sterile throughout. The formalin soaks into its interior, and not only makes it aseptic, but antiseptic. Micro-organisms cannot be cultivated on catgut treated with formalin. The gut will last seventeen days in the vagina, and longer buried in healthy tissue.—*Ibid.*

A NEW METHOD OF OPERATING ON VESICO-VAGINAL FISTULÆ (Freund).—Romm reports four cases operated on by Freund's method, which is a valuable resource in desperate cases. Freund opens the posterior vaginal vault, retroverts the uterus through the opening, freshens its posterior surface and the borders of the fistula and sutures the two surfaces. The uterus is then punctured at the fundus to allow the menstrual fluid to escape, if necessary. The method is only applicable to those cases where there is such an extensive destruction of the base of the bladder that the fistula can be closed in no other way. The uterus atrophies rapidly afterward, presumably in consequence of the twisting of the bloodvessels and diminution of nutrition.—*Centralblatt für Gynäkologie*, No. 7, 1899.

GEORGE R. SOUTHWICK, M.D.

PELVIC NEURITIS, OR INFLAMMATION OF THE PUDIC NERVE, IN WOMEN.—William O. McDonald, M.D., New York City, describes what he calls "Pelvic Neuritis." He recognizes two forms: One where the tenderness alone exists—this he calls the dormant form; in the other tenderness and spontaneous pain coexist—this he styles the active form. He has never met a case where, tenderness once being developed in a nerve trunk, it has ever entirely disappeared afterward. He has observed that the pain extends into the feet, knees, thighs, hands, head, buttocks, into the iliac, inguinal and hypogastric

regions, and even the whole length of the spine. He asserts that when a woman complains of persistent pelvic pain she has neuritis, no matter what else she may have.

His method of examination is as follows, he says: "It is my custom, after introducing my finger into the vagina, to seek for the evidences of inflammation of the pudic nerves before I palpate the cervix. For the left side of the pelvis the left index finger should be used, for the right side the right index. I first seek for the tuber of the ischium. Resting my thumb on this as a guide to the topography, I sweep the point of the index finger backward, making pressures, so to speak, at short intervals over the great sciatic notch, backward on the latero-posterior pelvic wall, deep into the sacral fossa by the side of the rectum, on the latero-anterior surface of the sacrum as far as I can reach toward the upper border of the bone, endeavoring to pass over the area of the sacral plexus and the trunk of the pudic nerve; then bringing the index finger forward, I press on the inner surfaces of the tuber and ramus of the ischium until I get up pretty close to the clitoris. This sweep of the finger comprises the extent of the pudic nerve trunk. The tenderness may extend wide of this into the area of distribution, but the greatest tenderness will be found by pressure on the trunk itself. Then using the right index finger, I go through the same procedure on the right side."

He claims that pudic neuritis is the most common disease of the pelvic organs of women, nearly 50 per cent. of his cases having suffered from this complaint.—*The American Journal of Obstetrics and Diseases of Women and Children*, Vol. xxxix., No. 2, 1899.

W. D. CARTER, M.D.

INFLUENCE OF TENOTOMY UPON VISION.—Dr. Wolffberg, of Breslau, discusses the effect of tenotomy upon the sight, and concludes that after a successful tenotomy the squinting eye is improved, not only as regards light, but also in color-sense. He mentions several cases which vindicate the soundness of his conclusions. He calls attention to the fact that surgeons hitherto have expected little beyond correction of the deformity, and he emphasizes the necessity of telling the patient that the improvement is not only a cosmetic one, but also a visual one. In discussing this question before the Academy of Medicine (Paris), Javal expressed the opinion that the best results are gotten where both eyes are operated upon. The proper age is between eight and ten years.

Fournier observed that strabismus was found so often in hereditary syphilis as to suggest the thought that there was a casual connection between the two affections.

In fifty-two children affected with hereditary syphilis there were twenty-one who squinted.

Almost half of such children squint. Furthermore, tuberculosis and alcoholism in the parents play a rôle in the ætiology of strabismus.

While Panas and Javal agreed in thinking that strabismus had no such origin as a central one, Panas contended that the best method was the operation on one eye only.—*Wochenschrift für Therapie und Hygiene des Auges*, Jan. 19, 1899.

INTERNAL TREATMENT OF GLAUCOMA.—The author quotes the opinion of Czermak, Schmidt-Rimpler, Jacobson, Everbusch and others, going to show the connection between glaucoma and gout. All of these observers suggest the advisability of employing anti-gouty remedies.

Walter reports a case of acute glaucoma where, in addition to instillations

of pilocarpine, one grain daily of piperazine was given internally for ten or fifteen days, with the effect of bringing about a complete disappearance of all the symptoms and a return to normal vision.

Still another case of a woman 56 years old, who had long been a sufferer with articular rheumatism, and one of whose eyes had been iridectomized for glaucoma. The other eye now showed symptoms of glaucoma. It may be said that the operation had not been successful, but had been followed by more or less degeneration of the eye with minus tension. The patient was put on one grain daily of the piperazine dissolved in carbonated water, and was kept on this treatment for three weeks. The result was a complete disappearance of all the glaucomatous symptoms. Most of the time no pilocarpine was used, so it was evident that the happy result must be attributed largely, if not entirely, to the internal treatment. It should be added that improvement was also marked in the eye which had been operated on unsuccessfully for glaucoma years previously.

While the author does not underrate the value and necessity of iridectomy in certain cases, he concludes that there are cases where the internal treatment in the manner suggested is of distinct benefit.—Dr. O. Walter, of Odessa.—*Die Ophthalmologische Klinik*, Nov. 5, 1898.

ON THE METHOD OF DEVELOPMENT OF CONJUNCTIVITIS.—Dr. Weeker, Paris, considering that the conjunctiva is not immediately infected, but that the germs lodge on the lids and then reach the membranes, suggests that more attention should be paid to the skin-surfaces that surround the eye than is now done in our efforts for prophylaxis. In the case of the new-born he recommends a thorough cleansing of the lids and the surrounding parts of the face, followed by sterilization by means of cyanide or oxycyanide of mercury. This is to be done immediately after the birth of the child, and is to be repeated as soon as possible after the first bath.—*La Clinique Ophthalmologique*, Jan. 10, 1899.

COCAINE, it seems, is being abused by the practitioner in treating diseases of the eye. According to a member of the editorial staff of the *Southwestern Medical Record*, physicians forget the injurious local effect of cocaine upon the nutrition of the cornea. In cases where it has to be applied for a considerable time, as in conjunctivitis, corneal ulcers, and other forms of eye-pain due to inflammation, it becomes quite hazardous. The practice is common of the general practitioner prescribing a solution of cocaine for eye-pains. When used thus for any considerable period of time it causes dryness of the cornea and looseness of the epithelium, thus increasing the pathological conditions of corneal ulcer.

Normally, corneal circulation is small, and therefore, to inhibit for a length of time its action is to decrease the vitality of corneal tissue. Its application deceives the physician by creating the impression that a serious condition may be trifling, because the pain is removed. The author asserts that he has known of several cases of plastic iritis prescribed for in this way, until sufficient adhesions had taken place to bind down the iris completely in its complete circumference.

For removing foreign bodies or applying silver nitrate or copper sulphate its application is admirable, but its continued instillation is dangerous, and especially useless in catarrhal inflammation of the conjunctiva.

WM. SPENCER, M.D.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND
THERAPEUTICS.

TREATMENT OF ECZEMA.—Dr. Tessier, lecturing, on eczema, asserts that *anacardium orientale* produces an erythematous eruption which, if prolonged, brings about vesicles, with burning and itching, with swelling, which ends in desquamation. Jahr states the characteristic symptom to be a burning pruritus, which is aggravated by scratching. Though it is but little employed in eczema, yet its pathogenesis justifies it here. (Kobert—*Lehrb. d' Intoxicationen*, p. 343—speaks of its causing erysipelatous and pustular dermatitis.)

Arnica.—A remedy which acts chiefly on the skin, whether it be taken internally or applied externally; and though the eruption is generally erythematous or erysipelatous, yet it may be eczematous. He once treated a lady who suffered from generalized eczema rubrum, following local application of the remedy. He has often found clinical experience confirm what pathogenesis and toxicology have presented under arnica.

Arsenic.—All schools recognize the influence of arsenic upon the skin. The formal indications are a dry, scaly, painful itching and burning skin, *i.e.*, the latter period of eczema, when with it rapid and complete results will be obtained. There is a nocturnal exacerbation of symptoms, and a febrile movement, accompanied by agitation and thirst. The twelfth to the thirtieth have appeared to him to act best, though he does not deny the efficacy of Fowler's solution.

Benzoic Acid.—Dr. Ozanam frequently prescribed this remedy, and especially the benzoate of soda, in eczema; and though he obtained incontestable results, yet its indications are somewhat empiric.

Bovista.—Fredault and Guerin-Meneville and Gonnard claim it to act in eczema of the back of the hands and forearms, for it has an elective affinity for these regions.

Cantharis.—A remedy for the first stages. All the world knows its vesicating powers, and he has often prescribed it, alternated with chloral, in the inflammatory and oozing stages of acute eczema. He employs the first decimal of both remedies. Dr. Jousset, Sr., has published cases of rapid recovery after this drug.

Chloral.—The chief drug for the pruritus. Its prolonged use brings about vaso-motor disturbances, as redness, swelling, pruritus and urticarial eruptions. Though properly indicated in urticaria, it is of service in controlling the itching of eczema.

Euphorbia and Croton Tiglium.—Two exanthematogenous remedies. Hughes recommends croton in holding the itching in check, though Tessier leans rather towards euphorbium (3x).

Graphites.—This drug contains a great number of cutaneous symptoms,

and particularly of eczema and other crusty and humid eruptions, sometimes associated with exudation of corrosive serum and itching in the evening and night. The skin excoriates easily, especially in children. Unhealthy skin; every scratch or injury tends to ulcerate. Tessier asserts that it has an elective action upon the nails. Digestive disturbances and constipation are precious indications. Internally, the 12x or the 30x, with an external application of a salve of 50 cgms. of graphites, 1x to vaseline, 15 gms.

Hydrocotyle Asiatica.—Eczema scroti, ani et vulvæ.

Mercurius.—One of the most powerful exanthematogenous remedies, and giving rise to numerous, very itching papules, which ulcerate, and become covered with scabs. Eczematous spots, which are excoriated, oozing, or dry and itching, or covered with fine scales.

Mezereum.—Very efficacious in eczema, and a rival of mercurius.

Rhus.—Both the *rhus toxicodendron* and *rhus vernix* are warmly recommended and employed by the homœopaths of all countries.

Sulphur.—The antiphlogistic *par excellence* of chronic inflammations.

Acidum Carbolicum.—An excellent remedy in eczema. In cases of the hypertrophic form, with ectropion of the eyelids, and associated eczema of the face or of other parts, it has been found excellent. Thus, in a case of a woman with generalized eczema, with resultant ectropion, who came to the Hôpital St. Jacques at Paris, this drug was administered in the third dilution, and in less than three weeks she was completely cured.

Externally, one may employ emollient powders, as of starch, oxide of zinc, talc, infusions of elder bark or chamomilla, or poultices of starch. There are some skins which will bear ointments, and then one may use one of the oxide of zinc. In the chronic form, one may use pyrogallie acid, 1.0; ichthyol, 2.0; salicylic acid, 50 cgms.; vaseline, 30.0.—*L'Art Medical*, No. 3, 1899.

CALCAREA CARBONICA IN NEURASTHENIA.—Dr. Alexander Villers, of Dresden, regards calc. carb. as one of the chief, if not the chief, remedy in neurasthenia; and though at times he employs *nux vom.*, *china* or *cimicifuga*, calc. carb. is that of which he first thinks.—*Homœopatisk Tidskrift*, No. 4, 1899.

VARICOSE VEINS DURING PREGNANCY, AND THEIR TREATMENT.—Dr. R. Haehl recommends:

Carbo Vegetabilis.—Varicose veins and ulcers, with malodorous and corroding discharge. The sore spots are only superficial, and have an irregular form. Inflammations that go on to suppuration or gangrene, with burning pains and decrease of strength; disturbances of digestion, with passage of stinking flatus; varicose veins on the genital organs, with bluish varices, which burn; ulcers and fistulas, with thin, sanious and corrosive vaginal discharges.

Fluoric Acid.—Varicose veins, with small and bluish ramifying venules at different spots; varices on the legs, with inclination to formation of ulcers.

Hamamelis.—Enlarged veins, with a feeling of soreness of the affected parts, especially during pregnancy; burning and bleeding hæmorrhoids, with weakness and pain in the back, as though it would break.

Pulsatilla.—Disturbances of the venous circulation; varicose veins on the legs, with a bluish tinge, with sore and stitching pains; passive hæmorrhages.—*Homœopathische Monatsblätter*, No. 4, 1899.

SLEEPLESSNESS DURING PREGNANCY.—Dr. R. Haehl speaks highly of:—

Aconitum.—Sleeplessness after midnight, with fearfulness, restlessness and tossing about; she keeps her eyes closed from anxiety; anxious and vivid dreams; insomnia, from a nervous fear that she would not be able to sleep, or in consequence of a gastric disturbance.

Belladonna.—Nervous excitement, in consequence of local congestion, causes the sleeplessness; a reddened face; headache; anxiety and restlessness; awakens with a start on going to sleep; complaining and tossing about; she feels sleepy, and yet cannot get to sleep; awakens the next morning very tired.

Coffea.—Sleeplessness in consequence of excitement, either mental or corporeal; joy or an agreeable surprise; from long watching or abuse of coffee. All the senses are overstimulated.

Hyoscyamus.—Sleep with much dreaming, from excitement, fever, jealousy, fear, or misfortune in love affairs. This remedy is particularly indicated for excited persons during pregnancy.

Nux Vomica.—Sleeplessness from disturbances of digestion. The patient takes a short morning nap, and then awakes tired and unrefreshed, with headache, bitter taste in her mouth, a coated tongue, etc.

Stramonium.—The patient awakes with a very important look, and all about her seems new. Sleeplessness, with tossing about in bed.

Passiflora.—Insomnia, with headache, from nervous exhaustion, following overexertion of the mind (an unreliable remedy).—*Trans. Homœopathische Monatsblätter*, No. 4, 1899.

TREATMENT OF DYSPEPSIA.—Dr. F. Cartier, of Paris, in a long article, considers the subject—dyspepsia. It is not a disease, but a symptom, and may be due either to an alteration of the stomach itself or of a distant organ.

Acute Gastritis and its Treatment.—Few remedies act as well in acute gastritis, with burning sensations and vomiting, as arsenicum; and, with milk diet, and the remedy in any dilution, the chances of success are good. If cramps complicate, alternate with *nux vom.* (why?). In a less degree, *puls.*, gastritis from pastry foods; *ant. crudum*, with nausea and diarrhœic stools; *bell.*, if the patient be congested; and, finally, *passiflora*, if the diagnosis be uncertain and a sedative be required. (An unreliable remedy.)

Hyperchloridria.—*Phos.* is very useful in burning in the stomach, rising into the œsophagus as though the mouth and tongue were skinned. Capsicum is a remedy full of promise in pyrosis and chronic burning in the stomach. From the third dec. dil. to the tincture. Conium is of service when there is amelioration on eating. *Nux* and *kali bich.* are useful in the mucous catarrh of the stomach of drunkards.

Hypochloridria.—The French homœopaths recommend an alternation of *nux* 6x one-half hour before meals, and *graphites* 12x a half-hour after, as one of the best measures in slow digestion. If there be sensitiveness of the epigastrium in a nervous subject, *lachesis* is better than graphites. According to Tessier, *gratiola* is worthy of confidence as a substitute for *nux* in dyspepsia, particularly in women with uterine disturbances.

Nux is especially indicated in men; while *gratiola* is in women what the former is in men, where there are pains, spasmodic disturbances, heaviness, yawning, dilatation, etc.

Lycopodium is indicated particularly where the liver is involved. Lack of secretion and contraction; desire for eating, which is quickly satisfied; a sleepy feeling after eating, constipation, etc.

Bryonia is useful in dryness of all the mucous membranes, with fæces like sheep's dung.

NITRIC ACID IN EXCESSIVE LACHRYMATION.—Dr. Goullon was consulted by a man who complained that his eyes watered greatly whenever he went out into the wind. His eye (right) was watery the whole day, even in the house. In the morning the lids would be stuck together. There was also a little headache over the eyes. His chest felt distressed and constricted, and he could speak neither long nor loud without feeling exhausted afterwards. Mornings and evenings he was bothered with pruritus ani. Nitric acid was given with good results. It is here a veritable specific, even when the cause appears to be a mechanical one. The drug was administered in the sixth decimal, and, later, a dose morning and evening. Later, hepar sulph. was given, for he has found from experience that these two remedies supplement each other. While, in eye diseases, at least in parenchymatous and pernicious corneal inflammations, aurum follows hepar well.—*Leipziger Populäre Zeitschrift fuer Homœopathie*, Nos. 7 and 8, 1899.

TREATMENT OF SOME DISEASES OF THE SKIN.—Dr. J. P. Tessier, of Paris, in a recent lecture on the homœopathic treatment of diseases of the skin, speaks highly of aconite in measles.

Aconitum is, in fact, the chief remedy. The pathogenesis, he asserts, indicates it, though it must be admitted that his evidence is slight. It is, from my experience, the chief remedy, because it controls the fever, and does not permit the disease to get the upper hand. He states that at the St. Jacques Hospital of Paris they have treated nearly three hundred cases of measles without a single death, while at the Hôpital des Enfants Malades and the Hôpital Trousseau the mortality was 20 to 30 per cent. Without wishing to deny the efficacy of drugs in this disease, any practitioner who has seen families in the country allow their children to run about with the measles out, or, at best, to keep them in the house, without any treatment except the warmth of the bed and all the water asked for, might permit himself the liberty of thinking that nature does a little for these children. As to drugs that will produce a morbilliform eruption, the only one that I know of is antipyrin, which will produce a typical measles eruption. I know of cases where it was almost impossible to diagnose it from measles.

Pulsatilla is preferred by many homœopaths. Its pathogenesis contains reddish patches on the skin, like the measles, with burning or often prickling itching.

In scarlatina, *belladonna* occupies the first place, and its pathogenesis is filled with indicative points. It is not, however, the only remedy.

Apis is another remedy of value, though not employed as often as bell.

Ailanthus and *arum* are recommended by English and American homœopaths; but though he has employed it often in the homœopathic hospital at Paris, yet he cannot praise its action. These former remedies are especially recommended in malignant cases, but here he, above all, prefers *arsenic* where there are signs of malignancy and prostration, not only in scarlatina, but also when these symptoms complicate pneumonia, typhoid fever, cholera, severe enteritis or nephritis.—*L'Art Medical*, No. 3, 1899.

TREATMENT OF VARICES.—Zincum 6x is a useful remedy when a patient with varicose veins complains of pain in them. Cramps caused by these veins are marvellously controlled by *cuprum* 6x, 12x and 30x. *Lycopodium* acts upon varices of hepatic origin, for this drug has a very marked influence on the liver. *Carduus Marianus* has been recommended here. *Fluoric acid* is highly praised by some English writers as having a long-lasting action on the veins and their tissues themselves. (I have greatly reduced a varicocele in size by the fluoride of calcium internally.)

Varicose Ulcers.—The French homœopaths employ *clématis* internally and externally in varicose ulcers—the sixth dec. dil. internally and an ointment of the tincture externally, with rest in bed.—*Revue Homœopathique Française*, No. 2, 1899.

TREATMENT OF HÆMATURIA DUE TO DISEASES OF THE PELVIS OF THE KIDNEYS.—Dr. R. Steiger recommends the following remedies:

Lycopodium.—Is indicated before all others in affections of the pelvis of the kidney and not of the parenchyma. This remedy influences and is indicated in the uric acid diathesis as well as in gout and the formation of renal stones and sand. It affects the right side of the body. There is sandy sediment in the urine and an acid state of the urine, as well as pain on urination. Renal colic. It is useful in all affections of the pelvis of the kidney and calices, which signifies its usefulness in catarrhal conditions of these parts, as well as in the formation of renal sand and stones with hæmorrhages.

Hepar Sulphur.—This remedy should be employed in cases with neutral and alkaline urine. Similar drugs are *natr. phos.*, *magnesia mur.* and *coccus cacti*, which are serviceable in alkaline urine.

Natrum mur., *lithium citr.*, *magnesia boro-citrica* (Paracelsus' drug) are employed in acid urine.

Berberis.—Indicated in pain in the kidneys, aggravated with every motion of the body. The pains are acute and cutting. It is an excellent remedy in stones in the kidneys or the ureters. The urine contains a reddish sediment, consisting of blood, mucus, epithelia and sand (urates).

Argentum Nitricum.—Dr. Treston first administered this drug in nephralgia, congestion of the kidneys and pains due to the passage of a stone through the ureters. Sudden attacks of desire to micturate. The urine is dark, bloody, with a precipitate of urates and epithelium from the pelvis of the kidneys.

Cantharis.—Also is indicated in painful passage of fragments of stones through the ureters. Urinary sand in children. *Cantharis* shortens the period of hæmorrhage and allows the stone to escape without suffering.

Tabacum.—This drug is of value in nephralgia with hæmorrhage when there is an accompanying deathly nausea.

In some cases only an injection of morphine will relieve the intense suffering of such patients.—*Vratch Gomeopat*, No. 6, 1898.—(Some homœopathic authorities assert that it is wrong to expect much action from our drugs selected according to our law to act in renal colic, for the cause is purely mechanical which drugs will not remove.)

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OSTEOMYELITIS.

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INTRODUCTION.

First Narrative.—About two years ago, while on a visit as a consultant in a suburban hospital, I was asked incidentally, by one of the staff, to see a case of bone disease. On being introduced to the patient, a denuded area two or three inches in diameter, just below the knee, was exposed to my view, which had been the site of an operation by the attending physician a few days previously. This operation had consisted in opening multiple sinuses, which had for a long time burrowed beneath the skin, and the removal of thin, necrotic, overlying integument. Upon interrogation I learned that, eighteen years before, the patient suffered from what was then called rheumatism, which had followed undue exposure, and had affected the right leg just below the knee. Recovery followed after the lapse of three months. For fourteen years he remained well. Recurrence of the trouble then transpired, with swelling, spontaneous opening, and suppuration. After a four months' illness he was able to resume his work. Four years later, which brought the case to the date of the present attack, the parts below the knee again became swollen and painful, pus exuding through three openings. The knee-joint had not at anytime been in-

vaded, and at the time of my examination was flexible. Exploration disclosed an opening extending through the compact bone and into the head of the tibia. A diagnosis of chronic osteomyelitis was rendered, with the advice to expose the anterior surface of the tibia, chisel away the bone, expose the abscess cavity beneath, and establish free drainage. I learned later that the case afterward entered another hospital, where an off-hand diagnosis of "tuberculosis" was rendered, and the limb amputated. This was a typical case of spontaneous osteomyelitis which had drifted into chronicity.

Second Narrative.—In July of 1898 a boy of 12 years sought treatment for some obscure malady of the right leg, supposed to be rheumatism. The initial symptoms had been severe pain about the knee, followed by a temperature of $103\frac{3}{5}^{\circ}$ F., pulse 126, headache, delirium, heavily coated tongue, dry lips, and diarrhœa. These had appeared suddenly, following long immersion and chill in swimming. Just above the knee there appeared later an area of induration and red discoloration. The leg was flexed and rigid. With the first symptom of pain, just above the knee, or referred to vaguely by the patient as in the knee, a diagnosis of rheumatism was made. Later, with the onset of dry, heavily coated tongue, high temperature and pulse, the case was thought to be typhoid fever. With the muttering delirium, rheumatic meningitis was suggested. Finally, when a swelling appeared just above the knee, with fluctuation and discharge of pus, the case was diagnosed as tuberculosis, and the abscess cavity freely opened and scraped out. This was a typical case of acute osteomyelitis.

Third Narrative.—About the 25th of December of last year a strong, robust man, a physician in one of the large cities of Massachusetts, was prostrated with a severe, deep-seated, agonizing, boring pain in the thigh. He had had, a few days previously, a tedious and exhausting case of confinement, incident to which he had gone without food or sleep for an unusual period. In the early morning following the labor he took a long drive to visit another patient, and became thoroughly chilled. He was seized with a pain in his thigh, so severe that he succumbed at once to it and sent for a brother physician. The case was thought to be sciatica. The pain was so intense that he resorted voluntarily to morphine. After the lapse of a

few weeks swelling along the middle portion of the femur was apparent, pain diminished, but tenderness on deep pressure continued. The enlargement was fusiform, had appeared rather suddenly, but with it came partial resumption of the use of the leg, which had been entirely incapacitated during the acute stage of the attack. The case was then thought to be osteosarcoma, and the possibility of hip-joint amputation suggested.

At this juncture the case fell into my hands. In view of the obscurity of the malady, and the fact that the early symptoms did not fully confirm a theory of sarcoma, an exploratory incision was made. The microscope showed that the tissue removed was not sarcoma, but was purely inflammatory. Further exploration demonstrated that the case was osteomyelitis.

All the cases above briefly enumerated are examples of osteomyelitis. Two were typical cases, regarding which there could have been no question from the beginning. The third was obscure in the highest degree. This is my apology for bringing this subject, osteomyelitis, to your consideration to-day. In the first case a leg was sacrificed because of error in diagnosis. In the second an osteomyelitis was treated as rheumatism, typhoid fever, rheumatic meningitis, and tubercular abscess. In the third case a physician was in imminent danger of losing a limb, and perhaps his life, from a projected hip-joint amputation. These cases are not presented in any spirit of criticism, but only to illustrate the state of apathy which at present exists in the profession regarding a fairly common disease. This subject has been chosen from a somewhat selfish motive, for I desire to learn the opinion of my colleagues upon a matter which is to me of the utmost interest.

Synonyms.—Osteomyelitis, medullitis, endosteitis, osteitis interna, phlebitis of the bone, bone abscess, pseudo-rheumatism, bone typhoid, bone furuncle.

Explanatory Note.—In this paper the spontaneous form only of osteomyelitis will be considered. For a long time an inflammation of the bone marrow and the bone itself, especially prior to the days of antiseptic surgery, has been recognized as a sequel to operations involving bone. Unclean instruments, hands, ligatures or sponges, engraft pyogenic micrococci within an amputation wound. Suppuration follows, the wide-open medullary canal is an inviting path for extension of infection,

and post-operative osteomyelitis follows. The surgical history of the War of the Rebellion is rich in illustrations of cases of osteomyelitis following bullet wounds in bones and operations upon injured limbs. There is no obscurity regarding bone inflammation of this character. Such, however, is almost unknown at the present day, with modern perfection of surgical technique. It is the *spontaneous variety of osteomyelitis* only which interests us at the present time. This occurs without apparent cause, appears unheralded, without direct infection, mostly in childhood and youth, and is seldom met with after the skeleton becomes fully ossified.

Pathology.—Osteomyelitis is now known to be the result of microbic infection of the bone marrow. In the plainest and simplest terms, it is a bone abscess. It is found in the long bones, and most frequently at the epiphyseal junction in the lower end of the femur and the head of the tibia. Nevertheless, it may be met in any of the long bones, and at any point along the medullary canal. It is estimated that seventy-three per cent. of all cases are located in the femur. A series of bacteriological examinations of the pus from cases of osteomyelitis all show the presence of micro-organisms, and more frequently than any other the ordinary pus-producing staphylococci.

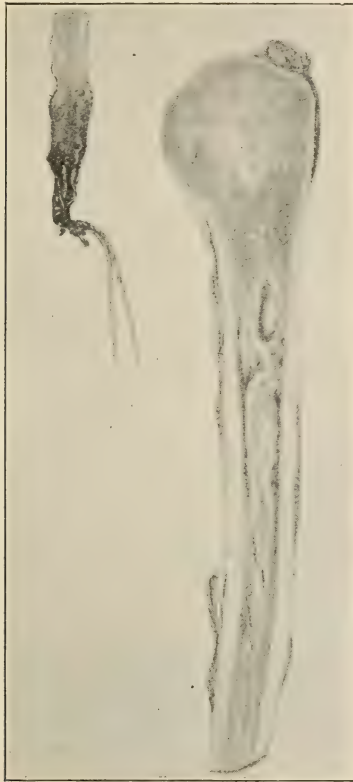
As I have said, a large number of cases of osteomyelitis occur spontaneously, *i.e.*, without any apparent cause. After the disease is well established it will usually be remembered that the patient has been subjected to some extraordinary fatigue, or has, when in an overheated state, suffered sudden lowering of bodily temperature through indiscreet bathing, reclining upon damp, cold ground, or exposure to a chilling atmosphere without suitable clothing.

Now and then an osteomyelitis follows quickly after the appearance of a boil upon some part of the body. Indeed, the semblance is so striking between a boil and an osteomyelitis that the latter has been called bone furuncle. Bacteriological examination shows identically the same microbic infection, and the gross pathological process is the same, modified only by environment.

Osteomyelitis occasionally follows an attack of some acute febrile infectious disease, as typhoid fever, scarlet fever, variola, chicken-pox, measles, pneumonia and diphtheria. The typhoid

bacillus has been found in the pus of osteomyelitis, also the pneumococcus. The disease is very infrequent after diphtheria, one case only having been reported. It has frequently been observed after variola. In such cases of the latter as have been examined the ordinary pyogenic bacteria have been found, presumably in addition to the specific variola organism which has not yet been

FIG. 1.



Osteomyelitis.—Surgical History of the War of the Rebellion.
Shows the early changes incident to infection of medulla.

isolated. During the past few years attacks of grippe have in rare instances been followed by osteomyelitis. From what has already been said, the inference must be drawn that in so-called spontaneous cases of osteomyelitis the infective material reaches the bone marrow by the way of the circulation. This is quite within the bounds of reason where it occurs as a sequel to con-

tagious diseases, for it is an established fact that the specific microbes of such infective diseases are distributed widely through the blood currents. Their lodgment in some favorable point in the bone marrow would appear to be only a matter of course. How pyogenic bacteria reach the circulation in cases not preceded by furunculosis or general contagion is often difficult to divine. It may be by way of the respiratory tract or the intestinal canal. Kocher fed putrid matter to dogs, and succeeded in producing osteomyelitis, in some cases, at the site of experimental fracture.

The prevalence of osteomyelitis in childhood and youth, and its location at the epiphyseal line of long bones, is supposed to be due to some favorable condition existing in that location and at that time of life. It is the time and place of rapidly developing bony tissue. Bone cartilage and new capillaries are building up to provide for the natural growth. This newly formed tissue is supposed to be less resistant to the attack of bacteria than maturer structures. It is conceded that the common bacteria of suppuration, the yellow and white micrococci, even in health, are liable at all times, in moderate numbers, to be circulating in the blood current. Depression of vitality from any cause (sudden chilling after the patient has become overheated or exhausted from exertion) destroys the equilibrium, and localized abscesses within the medullary cavity of the bone follow. Such an abscess differs from a pyogenic abscess elsewhere only on account of its environment. The pyogenic organisms find a suitable pabulum for their growth and multiplication in the medullary tissue. The normal tissue is destroyed and a pus cavity is formed, all within the dense, unyielding shell of compact bone. The microbic infection extends along the Haversian canal, intra-osteal pressure is augmented, great pain follows, little by little, at some point, the compact bony tissue breaks down and gives way, until perforation follows. The periosteum is then infected, also perforated, and the pus becomes disseminated through the soft tissues overlying the point of perforation of the bone. Thus the microbic infection is first an osteomyelitis, then an osteitis, later a periosteitis, and finally a diffuse abscess, infiltrating all the surrounding soft parts.

The Involucrum.—Coincident with the approach of the destructive inflammation to the periosteal covering of the part of

the bone affected, activity occurs in the production of new bone. A peripheral layer of osseous tissue forms all over and around that part of the shaft which is menaced. In extreme cases the whole diaphysis dies and separates from the epiphysis. Nature, in anticipation of this, provides an envelope of new

FIG. 2.



Osteomyelitis.—Boston University.—Pathological Museum.

Enormous involucrum incident to osteomyelitis of upper end of ulna. Note the large buttresses of new bone.

bone—the involucrum—which perpetuates the form and outline of the limb, and finally, if the patient's life continue, and the limb be saved, takes the place wholly or in part of the destroyed shaft.

The Sequestrum.—The portion of the shaft which has been

destroyed is thus surrounded by the involucrum. In other words, it is sequestered. It remains thus a long time buried—a dense mass of bone, disintegrating, but slowly—a foreign body, a focus for microbic germination and suppuration. Bit by bit it finally crumbles and finds its way out through the sinuses which nature has provided.

FIG. 3.



Osteomyelitis.—Surgical History of the War of the Rebellion.
Shows enormous involucra of radius and ulna. Large sequestrum of radius shows through cloaca.

The Cloaca.—The involucrum never forms an impermeable envelope about the sequestrum. One or more apertures are maintained—conduits for the exit of pus and cast-off spiculæ of the sequestrum. These cloacæ are always inadequate, easily obstructed, and provide but poorly for the overflow.

Spontaneous Fracture.—It sometimes occurs that the destructive progress of the disease is very rapid and the formation of the involucrum is slow. As a result of voluntary movements of the limb in bed, fracture of the weakened bone may occur. It is my belief, though, that this is very rare; for the patient guards the tender, painful limb most carefully.

Clinical Picture—Symptoms.—The train of symptoms of an ordinary, acute, spontaneous osteomyelitis are so clear and unmistakable that there should rarely be a mistake in diagnosis. It is true that in acutely virulent cases the early symptom of localized pain may be overlooked, or forgotten, or shrouded in the more disquieting sequelæ of delirium, dry tongue, high temperature, rapid pulse and diarrhœa. With the presence of such a profoundly toxic condition the very earliest symptoms should be zealously sought and every move of the patient in the days immediately prior to the onset of the attack diligently scrutinized. The patient is, in a large percentage of cases, a child or youth. The first symptom is a localized pain in one of the long bones at its epiphyseal line, and usually it is the lower end of the femur or the upper end of the tibia, so near the knee-joint that the patient sometimes refers it to that articulation. More than one bone may be simultaneously affected, but usually there is but a single point of infection. The patient complains of pain in the affected part, but there is no swelling in the first days of the attack and no evidence of inflammation. As the days go by the pain intensifies until it is out of all proportion to the apparent local conditions. The limb is at once and totally disabled. The patient rebels against any suggestion even of disturbing it in any way, complains of the jar of persons walking about the room, vibration of the bed, and the weight of the bedclothes. He cries in agony; the suffering is intense, the temperature rapidly increases, the tongue becomes heavily coated, delirium and diarrhœa ensue. Fatality may supervene within a week of the initial symptoms. If the patient does not succumb, there appears rather suddenly, sometimes within two weeks of the initial symptoms, swelling of the soft parts in the immediate locality of the pain. The skin becomes livid, fluctuation is presently apparent, and an exudation of pus occurs spontaneously or as a result of puncture with a scalpel. With the appearance of the swelling and pe-

ripheral inflammation, the intensity of the pain is modified, and with the discharge of pus great relief follows. The temperature falls, the tongue clears, delirium, if it has been present, vanishes, and the patient's general condition radically improves. From now on one of the two following-described sequelæ ensues, viz.:

First. After the lapse of weeks or months repair may occur, with resumption of perfect function of the parts involved; or,

Second. The case drifts into a chronic state; the abscess cavity does not heal, sinuses of the soft parts multiply, the neighboring parts are gradually encroached upon, the adjacent joint participates in the inflammation, etc.

Recurrence long after recovery from the original attack sometimes occurs. An acute case goes through all the phases of an osteomyelitis; repair and final recovery follow. After the lapse of years, with or without apparent reason, deep-seated grinding pain develops at or near the original site, with a repetition of abscess, sinuses, swelling, extension maybe to neighboring joints, permanent impairment, and possibly loss of limb.

Four years ago a recurrent case sought surgical aid. It was of unusual interest, in that fourteen years had elapsed after the acute attack, during which the limb was perfect functionally and showed no trace of the original trouble except a cicatrice. The second phase of the abscess was induced by a night-before-the-Fourth frolic about town. It came to my observation fifteen months later, having then destroyed the knee-joint, extended the whole length of the shaft of the femur, and showed multiple sinuses, five in number, opening in various directions about the knee.

The past winter a case came under my observation in which, seven years before, an osteomyelitis of the humerus had recovered, but left the shoulder- and elbow-joints ankylosed. Scars of many sinuses were visible about the shoulder, axilla, and along the upper arm. At the time of which I speak a deep-seated, constant pain along the shaft of the humerus had developed, tender on deep pressure, no remission of pain day or night. Thoroughly convinced that it was a recurrence of osteomyelitis, I exposed the anterior surface of the humerus, chiselled through it, and out gushed pus. Up to this time no swelling or reddening of the soft parts was manifest.

Diagnosis.—The diagnosis of a case of osteomyelitis is, as a rule, easy. There are now and then obscure cases which run an atypical course. Its occurrence, almost exclusively in childhood, naturally leads one to watch with great circumspection any acute attack of pain in the long bones, such as on first

FIG. 4.



Osteomyelitis.—Surgical History of the War of the Rebellion.

Shows bony changes incident to osteomyelitis of the lower end of humerus.

Note the well-formed cloaca.

contemplation might appear like rheumatism. In adults it is very rare as a spontaneous affection, and yet it must be borne in mind that it occasionally occurs. The persistent, intolerable, torturing pain located in a long bone should awaken the gravest suspicion of an osteomyelitis. Pain of this kind does not ameliorate; it continues day and night for a week or ten days.

The patient is obdurate in his demands for relief. (In the adult the location of the pain is quite as likely to be along the shaft of the bone as at, or near, one extremity—the conditions no longer exist which render the osseous structure more pregnable at the epiphyseal line. The developmental years of childhood have passed, ossification is complete, one part of the medullary canal is as liable to be the focus of infection as an-

FIG. 5.
No. 1. No. 2. No. 3.



No. 1. A fine example of osteomyelitis of the tibia with large involucrum and well-marked cloaca. No. 2. A sequestrum, consisting of nearly the whole of the shaft of the tibia. No. 3. Ulna and radius fused together in an extensive involucrum. A piece of dead shaft of ulna is seen through cloaca.

other.) At the expiration of ten days or two weeks an abatement of pain, simultaneously accompanied by a rather sudden swelling of the adjacent soft parts, is a convincing point in diagnosis. I am in doubt whether the temperature and pulse constitute a guide of any reliability. It has been my observation that in some cases, especially the rapidly fulminating ones, a marked elevation of temperature and pulse accompanies the disease, while in other cases the change from normal conditions

is but slight. It is considered that the temperature of osteomyelitis is subject to less marked evening exacerbations than in typhoid fever or acute rheumatism.

Differential Diagnosis.

OSTEOMYELITIS.	ACUTE ARTICULAR RHEUMATISM.	TYPHOID FEVER.
Common in childhood and youth, rare in adults.	Common in childhood and adults.	Common at any age.
Pain continuous, agonizing, localized in a long bone, near, not in, the joint.	Pain usually in more than one joint, changes from original location and varies in intensity.	No localized pain in any bone or joint.
Swelling and redness appear late, after lapse of seven to ten days, and with it pain ameliorates.	Swelling and pain appear with first symptoms; pain ameliorates as swelling diminishes.	No localized swelling or redness in any bone or joint.
Swelling and redness usually terminate in suppuration.	Swelling and redness fade away without suppuration.	
Delirium sometimes present, and occurs early within the first week, may be the third day.	No delirium.	Delirium sometimes present, but rarely occurs before the second week.
Temperature does not fluctuate, and as a rule does not go high, rarely above 102-3°.	Temperature runs low, 101°, rarely 102°, without marked fluctuation.	Temperature high at night, low in the morning, reaches 104° and higher.
Diarrhœa early, especially in profoundly septic cases.	No diarrhœa.	Diarrhœa in the first week of the attack or later.

Prognosis.—The prognosis in a case of osteomyelitis is, under modern methods of treatment, favorable. In childhood and youth, with the usually excellent health which is present at that age, the treatment of the disease on modern lines, *i.e.*, prompt recognition of the pathological processes and equally prompt surgical interference, should save every case. Under the old methods of treatment, with tardy diagnosis and surgical interference withheld, there is a recorded mortality of $23\frac{3}{10}$ per cent. We may hence conclude that with modern enlightenment regarding the pathology of the disease, coupled with intelligent surgical treatment, the prognosis is excellent for preservation of life, and for recovery without serious defect.

Treatment.—In a case of osteomyelitis the physical environment of the focus of the disease must be accepted as the deter-

mining element in deciding upon treatment. There may, and probably will be, in every case a lapse of a day or two following the first onset of symptoms before the diagnosis is made, or, indeed, before the physician sees the case at all. In this period of doubt, abortive medical and local treatment may be efficacious and should always be employed. According to experience with similar acute inflammations elsewhere, belladonna internally and a cold pack about the infected parts should do good in retarding the progress of the inflammation, if they do not wholly arrest it. After a diagnosis is made, resort promptly to surgery. Remember that we are dealing with a pyogenic abscess, with rapid germination of micro-organism and equally rapid pus accumulation. This is all imprisoned within the dense compact bone surrounding the medullary canal. A free opening through the overlying soft parts and trephining, or chiselling through the bone to the medullary canal, gives exit at once to the septic pus accumulation, and relieves as quickly the menace to the patient's life. This, of course, is simply following out nature's example, only anticipating her and doing it better than she does it. If the abscess is allowed to take its own course an outlet finally forms spontaneously, though inadequate for the best results in drainage. A promptly made artificial opening early in the disease, so fashioned as to expose fully the deepest recesses of the cavity, together with a thorough disinfection with peroxide of hydrogen, or formalin, should remove the menace to the patient's life and establish convalescence, with prompt and satisfactory repair. In the chronic form of spontaneous osteomyelitis, after all the stages of development have been passed through, and immediate danger to the patient's life has been averted, we can then deal more deliberately with the case. A chronic abscess of the medullary cavity communicates externally through the bone sinus and one or more sinuses of the overlying soft parts. (Inadequate drainage is thus perpetuated.) The external apertures of the sinus in the soft parts may not coincide in location with the sinus in the bone. A secondary pus cavity sometimes exists between the external surface of the bone and the skin. Indeed, a secondary periostitis will have long ere this existed, but an involucrum of new bone will have formed beneath the periosteum and all over that part of the shaft which has undergone destruction.

Under such circumstances the soft parts should be widely laid open, the lips of the wound retracted, all sloughing and pyogenic tissue curetted away, the sinus extending into the bone sought for, and with gouge and chisel enlarged by cutting away the surrounding bone, and free access established to the cavity beneath. The bone chiselled away may be wholly newly formed tissue—involucrum. In case the sinus communicating with the interior is not readily found, an opening should be boldly chiselled down through the presenting bone until the abscess cavity is reached. Within the cavity may be found spiculæ of necrosed bone—sequestra. Sometimes small sequestra are found, at other times enormous ones. Occasionally the whole, or nearly the whole, of the shaft of the infected bone is thus cast off, its function for the support and outline of the limb having been assumed by the newly formed involucrum. The bony walls surrounding these abscesses become, in these chronic cases, extremely dense—eburnated. With such wide opening and removal of necrosed bone the resulting cavity is slow to undergo repair. If healing occurs at all it must be by the gradual filling of the cavity with granulations, and the slow growing over and into the cavity of epithelium. The tendency is for the soft parts outside to contract and cover the wound superficially, still leaving the cavity beneath. As long as the external wound remains wide open, and the cavity is daily syringed, the patient does not suffer, except from the annoyance of the discharging sore. The limb may recover its function and the patient be otherwise well. Various devices for the purpose of expediting repair in these annoying cases have been resorted to. Shedd's method of repair with the aid of an aseptic blood-clot and Senn's method of bone grafting have been exploited with indifferent success.

Shedd's Aseptic Blood-Clot.—In this method, after the bone cavity has been thoroughly cleaned out and made aseptic through the use of chemical antiseptics (this is an inexorable condition), it is allowed to fill with blood, the soft parts are tightly closed without drainage, and the wound is left to itself. The blood forms a clot which serves as a matrix for connective tissue, bloodvessels, bony deposit, and final obliteration of the cavity. There are so many possibilities of a slip in this method that it is a very unreliable scheme. To begin with, the sur-

rounding tissues, the bone involved, and in fact the whole field of operation, is septic. A blood-clot remaining within such a cavity is a most putrescible and infective material; and the likelihood of such infection occurring, with subsequent breaking down of the clot and bursting open of the wound, is so great, that the method is rarely resorted to nowadays.

Senn's Method of Bone-Grafting.—This consists in packing the cavity, which has previously been made as aseptic as possible, with decalcified bone-chips. A bullock's bone is macerated in benzine to remove the fat, decalcified in dilute hydrochloric acid, then cut up into small chips. These are sterilized by soaking in carbolic acid, sublimate, or formalin solution, washed in sterile water, then packed firmly into the bone cavity, filling it to the brim. The wound is then tightly closed over this, and the interstices between the bone-chips are allowed to fill in with blood. Under favorable conditions organization takes place, bloodvessels permeate the interstices, and obliteration of the cavity results. The same difficulty is met with here as before, namely, the difficulty of rendering the cavity sterile, and the danger of the packing becoming infected, pus forming, and bursting open of the wound.

Cases.—A report of a long list of cases, many of them almost identical in symptoms and career, is of little value as supplementary to an article of this kind, hence I will not take time and space to portray more than a few typical cases. These may well be divided into :

Acute, with fatality; acute, with recovery, with operation; chronic, a continuation of the acute attack; chronic, a recurrence months or years after recovery from the acute attack.

An Acute Case With Fatality Without Operation.—The first case of osteomyelitis which came under my observation occurred years ago, early in my professional career, and before our present ideas of the origin and cause of the disease were established. A man of about 50 years of age, a baker by trade, was prostrated by a sudden attack of pain located just below the knee. This was the sequel to an exhausting march in a procession, in which he became greatly fatigued. A chill followed, with the development of the painful symptoms before mentioned, and the trouble was diagnosed as rheumatism. He rapidly developed a high temperature and rapid pulse, extreme dryness of the

mouth, heavily coated tongue, delirium and diarrhœa. After the lapse of four or five days swelling and redness of the soft part below the knee appeared, and almost simultaneously a pyæmic abscess of the lung. Death promptly supervened. This was a typical acute fatal case of osteomyelitis, occurring in an adult. It ran a natural course, apparently uninfluenced by treatment, and without surgical interference.

An Acute Case, with Recovery with Operation.—Master Willie L. D., aged 14, experienced, on rising one morning a day or two following a romping game of foot-ball, a painful sensation about the ankle, accompanied by slight chilliness. The next morning, on rising, he again was cold and chilly, with increase of soreness and pain. His temperature was 100°, but no swelling of the ankle was observed, although it was somewhat tender on deep pressure. Two or three days later the ankle began to swell, becoming especially painful at night. When I was called in consultation there was decided swelling and fluctuation over the lower part of the tibia, just above the ankle-joint. Operation was advised and performed without delay. The soft parts were incised longitudinally, the bone exposed, and a sinus found leading to the medullary canal, which was widely enlarged by chiselling away the surrounding bone. An appreciable involucrum had formed about the involved part, and, within, a sequestrum of considerable size was removed. The ankle-joint was not invaded. The whole cavity was thoroughly cleared, and the wound left widely open and packed with gauze. It was dressed daily thereafter, and irrigated with peroxide of hydrogen. Recovery slowly followed, and has been permanent during the three years which have elapsed since the operation.

A Chronic Case, a Continuation of an Acute Attack.—Mr. W., aged 48, had the initial attack thirty years before. It commenced with a chill, followed by agonizing pain just above the knee, which was finally relieved through the spontaneous discharge of pus. A sinus had persisted all these years, with periodical discharge of bony spiculæ. The disease involved the knee-joint years before, and ankylosed it. For many years the disease had remained quiescent, but in the last few weeks it assumed a threatening character, with a profuse offensive discharge and great swelling of the soft parts. Operation was

advised and performed, with the idea of relieving the immediately acute and threatening condition. A longitudinal incision was made along the lower part of the shaft of the femur, exposing the epiphyseal portion. A very extensive and dense involucrum was found, with a narrow cloaca extending to the cavity beneath. This was widely enlarged and the freest possible exposure of the abscess cavity effected. Sequestra were found within, and floods of pus. After thorough cleaning out and chipping away of all diseased bone, a cavity four or five inches in length remained. Great improvement in condition followed, the wide-open aperture permitting daily irrigation. The swelling of the soft parts rapidly diminished. About seven weeks after, the bone cavity still remaining without prospect of filling in, Senn's method of bone-grafting was resorted to. The cavity was again cleaned out by curetting and disinfection with peroxide of hydrogen solution, and lastly with salt solution. The cavity thus cleaned was packed with aseptic decalcified bone-chips and the wound closed. This resulted in total failure as far as the end sought for was concerned. The wound reopened, the chips were discharged, and daily irrigation was again resorted to. Subsequent exploration of the cavity showed that a portion of the bone-chips had become adherent all over the interior, with profuse granulations springing up all about and over them which were extremely sensitive to touch. It was my wish and desire to follow up this case, and with the advantage thus gained again resort to bone-grafting, but with the termination of my hospital service at about that time the case fell into other hands and amputation was performed.

A Chronic Case, Recurrence Months or Years after the Acute Attack.—Mr. A., aged 30, had an acute attack of osteomyelitis, located at the lower end of the femur, at 14 years of age, induced through exposure in running through the snow without shoes or stockings as an act of bravado. The ordinary symptoms of osteomyelitis supervened, namely, acute, severe pain above and about the knee, fever, and finally a swelling and discharge of pus, which continued over a period of months. Recovery followed, with healing and perfect use of the limb. No trouble was experienced for fifteen years, when, after an indiscretion in a nocturnal frolic, pain again appeared in the

old locality, followed by swelling and discharge of pus. There was gradual but steady progression of the inflammatory condition over a period of thirteen months, until, when the case came under my observation, there was a fusiform swelling extending above and below the knee, with many sinuses opening above, in front of and back of the knee-joint. From the long confinement indoors, and the drain upon his system, the patient was in a wretched physical condition. Exposure by incision was made, and it was found that the medullary canal of the femur was invaded through its whole length. The knee-joint was completely disorganized. Hip-joint amputation was decided upon and performed, with uncomplicated recovery.

THE REPORT OF THE FACULTY.

BY PEMBERTON DUDLEY, M.D., DEAN, PHILADELPHIA.

HAHNEMANN MEDICAL COLLEGE AND HOSPITAL.

PHILADELPHIA, May 10, 1899.

To the President and Members of the Alumni Association :

GENTLEMEN: On behalf of the College Faculty I beg leave to report as follows respecting the work of the Fifty-first Annual Session, just closed :

The number of students in attendance during the session was : Freshmen, 79 ; sophomores, 59 ; juniors, 58 ; seniors, 73 ; post-graduate, 1 ; total, 270.

The students who passed the final examination successfully, and who will receive the College degrees this evening, number 70, making the *total number of graduates to date* 2442.

In a conversation held last September with Hon. N. C. Schaeffer, State Superintendent of Public Instruction and President of the State Medical Council, he inquired as to the result of the College rule requiring an elementary acquaintance with Latin as a preliminary to matriculation. He seemed to me to entertain a doubt whether the College was able to live up to its rule, though he did not express it in words. Accordingly, soon after the opening of the session, and before the entire Freshman Class had matriculated, I prepared and forwarded to him a

careful report, exhibiting the names of seventy freshmen (all who had been matriculated up to that time) with the educational qualifications and credentials of each matriculate. The exhibit showed that the large majority of them had acquired the requisite knowledge of Latin in high schools, academies and colleges, and held duly authenticated certificates to that effect. Another portion of the class had pursued the study under a tutor, with the special object of meeting the pre-matriculate requirement, and presented certificates of progress from their tutors. Two or three passed in Latin before the Faculty's Examination Committee. The total result showed that about 10 per cent. of the Freshman Class had to be conditioned, and that 90 per cent. of the class measured up to the Latin requirement for admission to the College. The exhibit was an agreeable surprise to me, and I have not the slightest doubt that it was exceedingly gratifying to President Schaeffer.

Probably the most important advance or improvement in the curriculum during the year just closed was the extension of the Laboratory Course in Chemistry. This work now extends over two annual terms, instead of but one, as heretofore. The application of chemistry to medicine is constantly widening, and the extension of the Laboratory Course is timely.

While on this subject, I desire to state that Prof. Platt, who, by the way, enjoys no little distinction among the chemical scientists of the day, has expressed a strong desire to abandon totally the old scheme and methods of instruction in that department, and to substitute a new plan more in accord with the modern conditions of the science and more in harmony with present educational philosophy. When asked why he had not made the change, he replied, in effect, "Because, while the new scheme would make far better chemists, and especially better medical chemists, it would leave our graduates unable to pass the examinations of the various State Licensing Boards." I may add that Prof. Platt is not the only medical teacher who is complaining of being handicapped by our recent medical legislation. This fact, however, is not an argument against the existence of the State Boards, but it does suggest the necessity of bringing their work into more practical and co-operative relation with that of the medical schools.

Members of the Alumni Association, and homœopathic

physicians in general, are aware of the frequent expressions of professional dissatisfaction with the education of homœopathic students in the more strictly homœopathic branches. These unfavorable comments are directed against nearly or quite all the homœopathic schools of the United States, including our own Alma Mater. Indeed, I must admit that I personally hear more of them in reference to the school with which I hold official relation than any other. Possibly the teachers in other schools have a similar experience, but that is a matter with which we are not now concerned. We have before us the fact that our professional brethren think *our* students are not properly or sufficiently qualified in homœopathic practice.

We received, a few weeks ago, a communication written on behalf of a small but influential organization of homœopathic physicians of the western part of this State, in reference to this subject. The communication was of the most courteous and kindly nature, and breathed a spirit of friendly and intelligent interest in the welfare and usefulness of the college. So important did the matter seem, that a special meeting of the Faculty was called to take the subject under consideration, with a view to remedying the condition complained of, if possible, and at least to arrive at an understanding of the causes of the complaints, more particularly.

At that meeting, all the more important criticisms that had come to the knowledge of members of the Faculty were brought forward for discussion. It appeared that most of these criticisms were based on observations of the *practice* of our graduates, rather than on any knowledge which the critics had obtained respecting the practitioners' educational acquirements. This faulty practice is, of course, susceptible of two different explanations. It may be due either to the practitioner's lack of knowledge, or to his lack of a due conviction of the superior advantages of homœopathic treatment. It therefore became necessary to ascertain, if possible, to which of these causes the apparent lapse in practice must be ascribed, as a preliminary to the adoption of any efficient measures for its correction.

A careful study of the college curriculum and roster reveals the fact that the branches designated as "homœopathic" now occupy the following periods of time during the student's complete course: Homœopathic Pharmaceutics, 28 hours; Homœ-

opathic Materia Medica, 168 hours; Homœopathic Institutes, 28 hours; Homœopathic Therapeutics (Illustrated), 56 hours; Homœopathic Clinics, 168 hours; Homœopathic Sub-Clinics, 32 hours; total time devoted to instruction in homœopathy, 480 hours.

In the days when Hering, Lippe, Guernsey, Raue and Farrington were with us, and when their influence was so potent in moulding the policy and directing the work of the College, the total number of hours devoted to the strictly homœopathic portion of the student's education was less than three-fourths of what it is now, and the opportunities for clinical illustration were not worthy of comparison with what they are at the present time. Distinguished as these great men were for their learning and skill, there is no ground for the assertion that in the work of instruction they were any more skillful and efficient than their successors of to-day—or any more devoted and conscientious. Moreover, the final college examinations in recent years are at least as broad, as searching and as exacting as they were in the institution's earlier history; nor was the student's capacity to acquire knowledge any greater than it is now. We know that his preliminary education was far less than that of his latter-day *confrère*.

With these facts before us, we are forced to the conclusion that the defective quality of the practice of our young graduates is not due entirely, or even chiefly, to their lack of education, and that the college may not be to blame for it, after all. But let us look a little farther.

The modes and directions by which, and along which, medicine has advanced in recent years have attracted the close attention both of the profession and the world. During these years it has been utterly impossible for any intelligent practitioner of medicine to avoid the feeling and sentiment of intensest interest in the new methods of surgery and in the new fields into which surgery has carried its brilliant triumphs. But in the present discussion the significant fact is that the *certainty* of surgery has far outstripped the certainty of medicine. Because of this, our physicians, young and old, allopathic and homœopathic, have regarded with less concern the tendency to substitute surgery for medicine whenever and wherever the former method holds out its brilliant promises of alleviation or

of deliverance from danger. Again, the wonderful increase in our knowledge of disease causes is leading thousands of physicians into an endeavor to satisfy the demands of their professional office by treating, or trying to treat, the real or supposed cause of the disease under the mistaken notion, apparently, that removal of the originating cause will necessarily arrest the morbid processes.

But the chief and predominant cause of the noticeable defection in homœopathic practice, for which the colleges are being exclusively held responsible, is the widespread prevalence and the insidious influence of modern quackery, and especially its influence upon the opinions, ethics and practice of the medical profession. Not alone in our colleges, but in our hospitals and dispensaries, in our society discussions, in our journal articles, and even in our text-books, and last, but not least, in the offices and the daily practice of the vast majority of physicians of all schools, the evidences of its pernicious presence are all too plainly visible. Our eyes and ears are so familiarized with it that we are fast losing for it our old-time loathing and abhorrence. Quackery, like other forms of vice,

“Is a monster of such hideous mien,
That to be hated, needs but to be seen.
But seen too oft, familiar with her face,
We first endure, then pity, then embrace;”

and such has been our professional history with reference to modern quackery. So plausible have been its approaches, so insidious and deceptive its propositions, and so multiform its development, that the medical profession has been lulled into fancied security until we are now awaking to find ourselves well-nigh helpless in its tightening toils, and are learning that while we have slept the positions of the physician and the druggist have been reversed, and that the manufacturing pharmacist has become the prescriber, and the physician the mere dispenser of the pharmacist's more or less secret nostrums. When we alumni, and we college instructors, and we leading practitioners, and we moulders of professional opinion, dishonor ourselves and our calling by employing remedies on the recommendation of the flaunting advertisements of their manufacturers, is it any wonder that young graduates forget that there is such a thing

as honor among medical men, and begin to fancy that we are, after all, but little better than a community of quacks?

But, gentlemen, our Faculty has no desire to evade its full measure of responsibility for the present state of affairs. On this subject I happen to know that our teachers are rendering "line upon line, precept upon precept;" yet we equally assert that there are possibilities as yet unfulfilled, and efforts, such as have not been made heretofore in the college history, will mark the work of the coming session. But you will not—you must not—expect that our Alma Mater, alone and unaided, can stay the tide of professional disloyalty that rolls around her walls and surges in at all her windows. Meantime, criticisms and suggestions will be gladly and gratefully accepted, from whatever source.

TWO CASES OF CÆSARIAN SECTION.

BY THEODORE J. GRAMM, M.D., PHILADELPHIA.

(Read before the American Institute of Homœopathy, Atlantic City, June 23, 1899.)

THE interest that from time immemorial has existed in the Cæsarian section, the decided infrequency with which this operation is required in America, and the happy results now attending this operation that for centuries has been recognized as the greatest of all surgical operations, suggest the desirability of accurately recording all such cases. It was my lot to encounter the somewhat remarkable experience of meeting with two cases demanding this operation within two weeks, in the early part of January of the present year. The fact that both children were saved, and that both mothers made recoveries which were delightfully free from complications, adds interest to the cases. My intention is to submit a report of these two patients with but few comments at the present time, though desiring during the course of the narrative to emphasize some points which are believed to be of importance; for it will be observed that there are a number of circumstances, especially those existing at the time of the operation, which merit attention. The discussion of these is invited, as also of the newer methods of treatment which were pursued.

CASE I.—Patient of Dr. E. S. Sharpless. Is 20 years of age; a native of this country; her mother is a healthy woman; still living; her father died at the age of 22 of pulmonary phthisis; has no brothers or sisters; the patient was married two years ago.

At the age of 4 years the patient sustained a fracture of the right fibula from a fall down stairs. Shortly thereafter she became affected by disease of the spine, and, in consequence, had a number of abscesses at intervals, which discharged about the pelvis and buttocks, and necessitated her treatment in a hospital for sixteen weeks. As a remains of the tubercular abscesses from the spinal disease, she now has ten scars about the groins and on the buttocks, three of which are in the region of the sacrum. There is slight lateral curvature of the spine, and, in addition, there is kyphosis, the hump involving the lower lumbar vertebræ, and also affecting the upper part of the sacrum.

The measurements of this patient are of some interest. Her height is only 55 inches. Her height to the crest of the ilium is $34\frac{1}{2}$ inches. From the crest of the ilium to the vertex she measures $20\frac{1}{2}$ inches. From this it will be seen that the deficiency in her stature is due to the diminished length of the body from the ilium upwards.

The pelvic measurements are as follows: External, Sp. il., $9\frac{3}{4}$ inches; cr. il., $10\frac{1}{2}$ inches; external conjugate, $6\frac{1}{2}$ inches; estimated conjugata vera, $2\frac{1}{2}$ inches. Internal measurements: Oblique conjugate, 3 inches; from this the true conjugate is estimated to be $2\frac{1}{2}$ inches. The symphysis is fully of normal width. On introducing the finger into the vagina it is easily possible to follow the ilio-pectineal line around the pelvis posteriorly to the sacrum. Here this line is not an uninterrupted arc; but where the sacrum should complete the curve, there is an indentation whereby the iliac bones are brought more nearly together posteriorly. The oblique conjugate diameter is easily measured.

Shortly after marriage this patient became pregnant, and Dr. Sharpless was engaged to attend her. On January 16, 1898, at 3 P.M., she was taken with labor-pains, and suffered intensely. During the evening the doctor tried to deliver her by means of the forceps, but did not succeed, it being impossible to have

the head engage in the superior strait. About midnight I was called to the case, and on examination found that the child was dead. I then made but one trial to deliver her, with only slight traction of the forceps, and, failing, proceeded at once to craniotomy. The head was steadied on the superior strait and perforated, and the cranial contents removed. With the cranioclast, the squamous bones of the head were then cut away, so that only the base of the skull, with the lower jaw attached, remained as the representative of the foetal head. Even thus considerably diminished, it was only possible with the greatest difficulty to make the head engage and pass through the superior strait. The body of the child could only be made to engage after the pendulous abdomen containing the uterus and the foetus was lifted high up towards the sternum, at the same time making considerable pressure from above. The foetus was finally removed, but in its extraction it suffered the fracture of both clavicles, one humerus and several ribs. The patient likewise sustained a complete laceration of the perinæum. One of the main difficulties experienced in the delivery of the child was the fact that it could not be made to engage in the superior strait on account of the angle it presented to the plane of the superior strait; for the uterus and the child were practically outside of the normal line of even the pregnant body, and were contained within the greatly pendulous abdomen. There was not sufficient space between the symphysis and the sternum for the child to occupy during the endeavor to make it engage in the superior strait.

After some weeks of illness the patient recovered from her ordeal, but during that time she was affected by pains, apparently of a neuralgic character, down the right leg. Some œdema was also present, which would lead to the belief that the patient suffered some infection in the nature of phlebitis; and yet she formerly endured similar pains, and again had them after her section—that is, at a time when we were moderately certain that there was no infection.

Some time after this the patient again became pregnant. Her last menstrual period occurred on April 6, 1898. I first knew of her pregnancy in December of the same year, and, after taking the pelvic measurements, concluded that the child at this time was already too large to pass with safety through

the pelvis—that is, either with safety to itself or to the mother—and a craniotomy now offered only the same chances of success as before, and would surely be attended by considerable risk to the mother. I therefore determined to await the end of pregnancy, and then to take the much-diminished risk of the Cæsarian section. The estimated time of labor was January 11, 1899. I resolved to perform the section some days prior to that date, and January 5th was fixed upon.

Cæsarian Section.—The operation was performed at the home of the patient. The house while small was a new one, and all aseptic details were possible.

After the patient had been placed on the operating table, the pendulous abdomen was raised up somewhat by my first assistant and an incision was made in the median line, about seven inches long, but did not extend above the umbilicus. The abdominal walls were found to be most wonderfully thin, so that the peritoneal cavity was reached in but a few seconds. The uterus presented with its left horn in the median line. I had previously determined by auscultation that the child lay in the right sacro-anterior position. At the same time I had endeavored to locate the placental site, but the placental sounds were not particularly distinguishable on any part of the anterior portion of the uterus, so that I was led to believe that it might be situated posteriorly. When the abdomen was opened, I again tried to locate the placental site by the slight elevation and the area of increased vascularity and softness which the text-books say mark the place. No such appearances were discernible, and therefore the uterine incision was made in the heretofore classical location. The incision was deepened first towards the upper part of the uterus, and here a stream of dark blood greeted my scalpel, which was astonishing because of its quantity. I concluded at once that I had to deal with a placenta prævia Cæsariana, and at the same time thought that the lower margin of the placenta had been cut; for I now believed that since, at my auscultatory examination, no evidence of the placenta could be found anteriorly, that the placenta must be attached in the fundus uteri. I therefore at once deepened the incision more towards its lower portion, and here encountered a flow of blood that was greater, if possible, than the former one. From this I now felt certain that I had

to deal with a placenta presenting directly under the line of incision, and also that a stage of the operation had been reached at which some expedition was necessary. Therefore, these two violently bleeding points in the line of the incision were rapidly united with the scalpel; the right hand was inserted between the uterine walls and the placenta towards the left side of the uterus, and here the blue amniotic sac was distinctly seen, bulging with its contained amniotic fluid. The membranes were nicked with the knife, and the hand inserted in order to grasp the child, at the same time giving exit to the amniotic fluid. From this description it will be seen that the placenta was situated in a place which would hardly be regarded as probable, judging from the results obtained at the preliminary examination made for this purpose; that is to say, it was attached somewhat to the right on the anterior wall of the uterus, and the child virtually lay on the placenta, as will become apparent on consulting the photographs. The feet of the child were sought for and readily found, and the child was delivered by the feet. The cord was clamped in two places and cut, and the child, a male, handed to Dr. Sharpless, who gave it attention. It did not cry at once and was rather pale, but was resuscitated. Just six minutes had been occupied by the operation thus far.

The uterus was now lifted out of the abdominal cavity, or we might say that the abdominal walls were slipped back of the uterus, and a pad was placed there to protect the peritoneal cavity from becoming soiled. My first assistant, Dr. Charles Becker, who until now had closely approximated the abdominal walls to the uterus, then grasped the uterine arteries on each side of the uterus and made compression there, in order in a measure to control hæmorrhage. No elastic band was used for this purpose, as is done by some operators. The placenta was delivered without any difficulty whatever. From now on the hæmorrhage was remarkably scanty, for the uterine walls contracted at once. I cannot resist pausing for a moment to comment upon the wonderfully interesting spectacle presented by the uterine walls as they contracted and retracted, and evidently rearranged their fibres, so that the walls, which until now had had the thickness of only about 1 centimeter ($\frac{3}{8}$ inch), palpably thickened, and in a very short time the uterine walls were about 5 centimeters (2 inches) in thickness.

Ten deep and the same number of superficial sutures were inserted to close the uterine wound, after a strip of iodoform gauze had been passed through the uterine cavity. It then became manifest that we had been quite successful in preventing the peritoneal cavity from becoming soiled by any of the discharges; only one clot was found anterior to the uterus, at the lower angle of the abdominal incision. This was removed and the abdominal wound closed. It was my original intention to close the abdominal wound with buried silver wire sutures, but this was found to be impossible on account of the remarkable thinness of the abdominal walls. Therefore the peritonæum was closed with a continuous catgut suture, and then the fascia and the skin surface were brought together with fine silver wire. The usual abdominal dressing was applied, and the patient returned to bed in a most satisfactory condition.

It should have been remarked above that, at the urgent request of the patient and of her husband, I consented to remove the ovaries at the operation, in order to prevent the recurrence of pregnancy; and this was accordingly done after the uterine suture was completed.

After the operation the patient did not vomit at all, and became conscious in a very short time. During the first two days she suffered from frequent afterpains and cramps in the thighs, which were admirably controlled by the administration of viburnum, gtt. j tablets. For the first few days the temperature reached 100° F. in the evening, but was normal during the remainder of the day. This was the only rise, excepting on the fifth day, when 102° F. was reached. At the same time the right breast was somewhat more than usually congested; but this condition disappeared after massage, and the temperature likewise fell at once. The bowels were moved on the third day. The patient was allowed to sit up in the third week, having gained in weight; and, as her friends remarked, she looked better than before the operation.

The child was applied to the breast forty-four hours after the operation, and the nurse's chart says there was plenty of milk. The measurements of the child's head taken five hours after the operation showed that in every diameter it was of the size of the average fœtal head at term.

It might have been mentioned above that, while the abdom-

inal incision at the time of the operation was seven inches long, it had shrunk to such an extent by the eleventh day, when the sutures were removed, that it only measured two and a half inches. This was due to the fact of the abdominal walls having been so enormously stretched by the pendulous abdomen and incised while in that condition; the tissues had had time to so far retract by the time the sutures were removed that, unless these circumstances were known, it might be doubted that a full-grown child at term had ever passed through an incision so small as the scar on the abdomen would indicate it to have been.

CASE II.—Patient of Dr. Charles W. Karsner. Aged 32 years; primigravida; last menstrual period May 8, 1898; false labor-pains began during the night of January 17, 1899, and continued with long intermissions. At 4 P.M. on the following day Dr. Karsner visited her, and found the pains far apart. At about 8 P.M. on January 18th the amniotic fluid was discharged. The patient residing out of the city, Dr. Karsner reached her some hours later in the evening, and on examination found that a tumor obstructed the progress of the labor. He tried by pressure to displace it, the patient having been placed in the knee-chest position, but without avail. A messenger was sent for me, but because of the distance from the city I did not reach the patient until 1.30 A.M. on January 19, 1899.

I was told that the patient always menstruated regularly, for five days at a time, and had not suffered from leucorrhœa; had always been seriously affected with constipation, so that cathartics were constantly required. Patient suffered from dyspareunia from the first.

On vaginal examination I found that a large tumor completely filled the pelvis, so that the os was only found with the greatest difficulty immediately behind and above the symphysis pubis. Some dilatation had taken place, and the head of the child presented in the right occipito-anterior position. Between the tumor and the symphysis only one finger could be inserted. No more accurate measurements than this were possible at this time. Although Dr. Karsner had already attempted to displace the tumor with the patient in the knee-chest position and making pressure upwards, I determined to

make the attempt, but without success. The patient was also placed in the exaggerated Trendelenburg posture on an inverted chair, and strong pressure was made in the effort to displace the tumor, but with no success whatever.

The question of craniotomy and the Cæsarian section was carefully considered. The foetal heart having been heard still beating with normal regularity and vigor, and the patient being considerably weakened, nervous, and somewhat hysterical, in consequence of her long, ineffectual attempts at delivery, we concluded that the best chance for both mother and child pointed to the Cæsarian section. Fortunately Dr. Karsner had made no unnecessary vaginal examinations and no attempt at artificial delivery, so that we could be moderately certain that the vagina had not suffered much if any bruising; and, also, aseptic conditions had surrounded the patient up to this time. The consent of those interested having been obtained, the Cæsarian section was at once prepared for, the nurse in charge getting the patient ready for the operation, while I returned to the city for my instruments and for my assistants.

After having made the most careful preparations for an aseptic operation, the Cæsarian section was begun at 11.15 A.M. and completed at 11.45 A.M., January 19, 1899. Dr. H. A. Lacy administered the ether, while Dr. Karsner watched the condition of the patient. Dr. Charles Becker was my first assistant, while my nurse performed the duties of second assistant. An incision was rapidly made in the median line. When the peritoneal cavity was reached a small quantity of serum exuded. The uterus presented at once, and its anterior surface was incised in the median line. A very profuse hæmorrhage occurred immediately, for, as in the case above related, the incision opened the uterus at the placental insertion. In this instance the placenta was implanted on the right side of the anterior wall of the uterus, but about one inch of the placenta extended to the left of the median line. Not a moment was lost, but the hand was at once passed through the placenta and the membranes and the child grasped by its extremities, which were found, as expected, in the upper part of the uterus, and a male child was delivered, and cried lustily. The cord was clamped in two places and severed between, and the child handed to the obstetric nurse, who had no further

trouble in its resuscitation. The placenta, which had been loosened to a great extent by these manipulations, was easily removed, a few small clots were taken from the uterine cavity, and the closure of the uterine walls begun and effected by fifteen medium-sized sutures.

I would remark, in passing, that, had there been any delay in the extraction of the child after the uterine walls were incised, considerable impediment to its safe delivery would have been experienced; for the uterine walls were closely applied to the child, the amniotic fluid having been discharged some hours before, and thus, had any material time been given to the walls to contract any more after they were incised, the child could only have been delivered with difficulty, as has occurred on a number of former occasions, where from this cause the child was lost. Another observation made at the time was that, after the uterus was emptied, the walls of the uterus were very much slower in contracting than in the former case related, and therefore the loss of blood was greater than on that occasion. I believe that tardy contraction of the uterine walls in this case was caused by the fact that the uterine muscles were tired out by the futile attempts to empty the uterus during the hours of ineffectual labor. Although they were in a condition approaching tetanic rigidity at first, yet after the uterus was emptied they did not contract as rapidly as in the former case.

The uterine wound having been closed, an attempt was made to examine the tumor which had occasioned the operation. This was found to involve the right ovary and to be adherent deep in the pelvis posterior to the uterus, and to fill the pelvic cavity completely. On inquiry at this moment as to the condition of the patient, my anæsthetist informed me that while it was good, "yet it might be better." On this account I determined, with Dr. Karsner's concurrence, not to take any chances at present of removing the tumor, but to defer that until another occasion. I am very well aware that on theoretical grounds it might have been well to have removed the tumor at this time, but I am perfectly satisfied with the decision made, for the patient experienced a much better recovery than would probably have taken place had she been subjected to the increased time and the attending shock of another operation. We must also take into account that many more serious adhe-

sions might have been encountered than were otherwise expected, and thus the termination of the operation delayed; in addition, the enlarged uterus seriously interfered with gaining any assistance from the sense of sight deep down in the pelvis, had this become necessary for any reason. My whole thought during the operation was to terminate it as soon as the exigencies of the case would with safety permit. As it was, the patient sustained little shock, and recovered from the anæsthetic with very little vomiting. The abdominal wound was closed with catgut for the peritonæum, and silkworm-gut for the fascial, connective tissue and skin layers.

In regard to the after-treatment of this patient, there is only to be said that on the night of the second day post-operationem, the distention of the abdomen was extreme. The tympanites affected mainly the upper part of the abdomen, that is to say, that part of the abdomen where the walls had become extremely distended by the child having been mainly carried there, the tumor not having allowed the child to be carried in its normal place in the lower abdomen. The partial occlusion of the lower bowel caused by the tumor in the pelvis was also without doubt a material factor in causing the tympanites. The latter was relieved by high enemata and cathartics. The temperature only reached 100.6° F. on the evening of the day of the operation, and did not rise again. The case may, therefore, be regarded as having made an aseptic recovery.

The operation for the removal of the ovarian tumor which had occasioned the Cæsarian section just recorded was performed at 3 P.M. on May 4, 1899, at the home of the patient. The abdomen was incised about a quarter of an inch to the right of the scar of the former operation, and exposed the ovarian tumor. No adhesions were encountered at the site of the former incision, the peritonæum being found quite free and the scar very satisfactory. The abdominal viscera were in a normal condition. My left hand was introduced into the abdomen and pelvis, and liberated the quite general adherence of the tumor to the pelvic walls. The apex of the tumor was embedded in the extreme lower part of the pelvis, and even after being loosened there was some momentary difficulty in raising the tumor out of the pelvis. I determined to remove this tumor without rupturing it, if possible, for I entertained

some thought of its being of malignant character. This thought was suggested on account of the lower part of the tumor, when examined per vaginam, being distinctly nodular to touch. The presence of serum in the peritoneal cavity at the first operation and the appearance of the patient also suggested malignancy. The tumor was therefore removed unbroken, and it was found that a satisfactory pedicle could be obtained by the ligamentum latum dextrum, and here the ligature was applied. The patient lost very little blood.

The left ovary contained four cystic follicles, and was atrophic. These cysts were punctured; but in view of the fact that the previous pregnancy must have originated from an ovum derived from this ovary, and for the further reason that future pregnancy was desired, this ovary, after the conservative treatment mentioned, was allowed to remain. The patient recovered from this operation without incident.

The tumor removed is heart-shaped, the apex being located deep in the pelvis, and its measurements are as follows: vertical diameter, five and a half inches; antero-posterior, four and a half inches; horizontal, five inches. It is of the dermoid variety, containing large quantities of cholesterine, connective tissue masses, and hair.

The following comments are suggested for discussion:

1. The preliminary obstetric examination should be made in the case of every pregnant woman, as I have recently tried to emphasize.*

2. Pelvic measurements should be made of every pregnant woman, and especially of every deformed pregnant woman.

3. If an obstruction to labor be encountered, the case should be examined with exactness, to determine its character, so that no inapplicable measures be attempted which would only injure the patient and make her less amenable to required surgical aid.

4. In the second pregnancy of the first case, Cæsarian section was less hazardous than craniotomy; hence craniotomy was not permissible, especially in the presence of a living child.

5. The first patient sustained less shock and made a more rapid recovery than is sometimes seen after a so-called normal labor.

* *Hom. Jr. Obs. Gyn. & Pæd.*, March, 1899.

6. Symphysiotomy was not applicable in the first case, in view of the great probability of ankylosis of the sacro-iliac synchondroses.

7. Cæsarian section is safer and easier when performed some days before labor. There is no need of waiting for the onset of labor-pains, since the uterus, when emptied, contracts satisfactorily even when labor has not yet begun at the time of the operation.

8. After the amniotic fluid is discharged and labor-pains have continued for some time, the Cæsarian section is distinctly more difficult and hazardous than before.

9. Placenta prævia Cæsariana does not present insurmountable difficulties, provided the operation be quickly performed.

10. The greatly improved results of the Cæsarian section rest mainly upon asepsis and the suturing of the uterine wound.

11. Under the conditions existing in the second case, complicated by the ovarian tumor, the removal of the latter at a second operation was distinctly the safer procedure, as the results demonstrated.

PATHOLOGY OF ACUTE CATARRHAL PNEUMONIA IN CHILDREN.

BY P. SHARPLES HALL, M.D., PHILADELPHIA.

(Read before the American Institute of Homœopathy, June 21, 1899.)

THIS disease, which is also known as broncho-pneumonia, lobular pneumonia, is an acute form of inflammation, involving the parenchyma and air vesicles, occurring in isolated patches, and attacking one or a number of adjacent lobules in various parts of the lungs. It begins as an inflammation of the mucous membrane lining the alveoli, and secondarily involves the bronchi. The cause thereof is an irritant, probably one or more species of bacteria. Pathologically it is characterized by a catarrhal inflammation of the terminal bronchi, with an exudate into, and a desquamation of, the epithelial cells of the alveoli.

Etiology.—Lesions similar to those of broncho-pneumonia may be produced in animals by causing them to inhale steam or other irritating vapors. If to the vapor be added decomposing

organic matter, the resulting lesions are almost typical. The same results are produced by section of the vagus nerves, causing paralysis of the vocal bands and œsophagus, thus allowing particles of food and irritating secretions to be carried into the lungs by inspiration (aspiration pneumonia). To this class belong many of the diphtheritic pneumonias, and not infrequently in the newborn as a result of violent inspiratory efforts made while the head is descending the vagina. Thus while lobular pneumonia may occur as a primary inflammation, it is most frequently met with as a secondary affection in connection with measles, whooping-cough, scarlet fever, diphtheria, influenza, simple and catarrhal bronchitis in children. Causes predisposing to bronchitis also favor broncho-pneumonia. Improper nourishment, the continued breathing of vitiated atmosphere, children of a strumous diathesis, those confined to bed from injuries or deformities, and also chronic diarrhœa and rickets, predispose.

While the above are the principal exciting causes, the immediate cause, in the light of present research, is some species of micro-organism. The later writers class lobular pneumonia as an infectious inflammation, the cause thereof being generally either the diplococcus of pneumonia or the streptococcus pyogenes. The latest investigations go to show that the inflammation is due to the bacteria primarily attacking the mucous membrane of the air cells themselves, and secondarily involving the bronchi.

Of the bacteria found, the one most constantly present is the diplococcus of Frankel. This occurs in over fifty per cent. of the cases, either alone or associated with the streptococcus pyogenes, staphylococcus, pneumococcus of Friedlander, bacillus of typhoid, bacillus of influenza, or bacillus coli communis. Any of these or other forms may cause catarrhal pneumonia independent of the pneumococcus, but in cases of fever where the specific micro-organism is found the diplococcus is usually associated.

Pathology.—The post-mortem appearances vary considerably, but are more or less characteristic. Distributed irregularly over the surface of the pleura are seen slightly elevated patches varying in size from a pea to that of a hazel-nut, of a light-red or bluish color, and firmer than normal. Slight pressure

causes these to break down, and upon section they exude a whitish, non-frothy, muco-purulent fluid. Other less numerous areas, dark-red or gray in appearance and somewhat depressed, correspond to the points of pulmonary collapse (atelectasis). The pleuro, covering both the consolidated and atelectatic areas, is generally covered with a thin layer of fibrin. The lungs as a whole are crepitant, and float when placed in water, but the tissue of the pneumonic areas sink. Upon section, the mucous membrane of the trachea and larger bronchi may appear normal or may be congested. The smaller bronchi are nearly always inflamed, thickened, and contain pus. Around these thickened bronchi are areas of consolidation including one or more lobules, and besides these are patches of consolidated lobules without any bronchial involvement. Surrounding the pneumonic points there is always more or less œdema, and at times collapse or emphysema. Inflammation, enlargement, and softening of the bronchial glands is generally present. When the inflammation is severe or septic, abscesses or caseous degeneration results, often leading to extensive tissue destruction with cavity formation. Occasionally the consolidation of an entire or the larger part of one lobe gives the appearance of croupous pneumonia. At other times it runs a more chronic course, lasting for several months, leaving dilated and thickened bronchi with peribronchial changes, which later lead to cirrhosis.

Microscopically we have an inflammation of the terminal bronchi and alveolar septa immediately surrounding. The walls of both the bronchi and air spaces are thickened and infiltrated with round cells, the capillaries being dilated. The cavities of the alveoli are filled with desquamated epithelial cells, leucocytes, red-blood corpuscles, a fluid albuminous in character, and in severe cases some fibrin. The smaller tubes and alveoli are frequently so filled with exudate as to prevent any air entering. The inflamed lobules are separated from each other by a network of healthy and still crepitant lung tissue. The severity of the inflammation varies in different cases, and in the same case. There may be no other change than congestion. In other cases is added a catarrhal inflammation of the mucous membrane of the bronchi, followed by the characteristic consolidation, with the associated pleurisy, bronchial

dilatation and areas of atelectasis. Thus around the bronchi are found narrow zones varying from congestion to hepatization, the rest of the lungs in the latter cases being congested and oedematous.

If resolution takes place the exudate undergoes fatty degeneration, and is either absorbed or expectorated, at the same time the round-celled infiltration disappears from the septa and peri-bronchial tissues, and gradually the pulmonary parts return to normal.

On the other hand, resolution not taking place, the inflammation continuing for several weeks, the products thereof tend to the formation of new fibrous tissue, especially that outside the bronchial tubes. The bronchi, the peri-bronchial tissue and the alveolar septa become thickened. This new tissue extending, a broncho-pneumonia is gradually transformed into an interstitial fibrosis of the lungs.

THE DIFFERENTIAL DIAGNOSIS OF THE DIFFERENT DISEASES OF THE BLOOD.*

Translated by

FRANK H. PRITCHARD, M.D., MONROEVILLE, OHIO.

THIS section of the work is of such practical value that I thought it worthy of translating. He considers the different diseased states successively as follows:

Polycythæmic Plethora is a rare morbid sign which on the one hand may appear as an actual polyæmia and on the other only deserves the designation of a relative polycythæmia. The former, a much rarer form of disease, seems usually to be a congenital anomaly of the blood, while the latter, in the majority of cases, is due to vast losses of the fluid portion of the blood-plasma. Thus polycythæmia may be observed with extreme transudation from stasis of the blood in valvular heart diseases, as well as after polyuria and profuse watery evacuations from the bowels.

* From *Leitfaden der klinischen Diagnostik* von Blut, Auswurf und Harn von Dr. med. Ernst Graeber, Privat docent fuer innere Medicin in Muenchen. 176 pp. Benno Schwabe, Basle, Switzerland.

The diagnostic detection of an increase of the number of blood-corpuscles is only possible by counting them. After profuse sweating the same condition, polycythæmia, is possible.

Anæmia—oligocythæmia, hydræmia—appears in an acute form after losses of blood; in a chronic form in sudden, exhausting diseases.

The number of red corpuscles and hæmoglobin are decreased; the anomalies of size and number of the corpuscles vary according to the intensity of the anæmia. There is slight to moderate poikilocytosis, rarely extreme, however; relative, sometimes absolute augmentation of the leucocytes; the relative per cent. of the white corpuscles in some cases is normal, in others altered; the blood-plates in grave cases are often greatly changed; in severe cases of anæmia there are nucleated red blood-corpuscles; the degree of alcalescence is decreased below the normal, or merely at the border of the normal.

The relative state of the red corpuscles after severe loss of blood is worthy of notice. The number of red corpuscles noted within the first twenty-four hours sinks usually during the following two days slightly, and then gradually returns to the first figure noted; only on the fifth to the sixth or even the seventh day does a regeneration of the blood set in in those cases tending toward recovery. During this time one notices a relatively great difference among the red corpuscles with regard to their size, and especially and also as to their coloring matter. While during the first few days almost normal conditions are noted, one soon begins to detect, even in the fresh preparations, that some of the corpuscles are paler than the others, and that numerous small or even dwarf-corpuscles are to be seen, in the field, along with the normal ones. Simultaneously the hæmoglobin in quantity is relatively decreased. The more that the blood tends towards the normal the sooner do these anomalies disappear. They may, however, be noticed for weeks. The number of leucocytes is often not only relative, but also absolutely diminished.

Chlorosis may be very decidedly and sharply differentiated from anæmia by the typical blood-findings.

The number of corpuscles corresponds to the normal, but the hæmoglobin in quantity, on the contrary, often very decidedly decreased; alterations of size, corresponding to the severity of

the disease, are always present; there is from slight to moderate poikilocytosis; the leucocytes are normal; the blood-plates are often increased; the degree of alcalescence is up to the highest normal grade, or increased.

If hæmorrhages occur in chlorosis, then the picture of acute anæmia sets in, wherewith progressive restoration, usually the chlorotic symptoms, more and more enter into the foreground, until, as a final result of the cured anæmia, the original chlorosis is present.

When the chlorosis, in consequence of faulty nourishment, etc., is complicated with chronic anæmia, then the described symptomatic picture only changes, in that the numbers of blood-corpuscles decrease. Then, correspondingly, the quantity of hæmoglobin is relatively decreased, so that the coloring power of a single red corpuscle is, after as before, diminished. This variety of anæmic chlorosis is frequently met with in practice.

Pernicious anæmia is also to be sharply differentiated. There is an extreme diminution of the number of red corpuscles, which may be even reduced to a tenth part of the normal. The quantity of hæmoglobin is relatively augmented. There are extreme variations in size of the red blood-corpuscles, giant and dwarf forms, the latter being rarer, the leucocytes relatively increased. The relative percentage of the white corpuscles is usually quite increased; the blood-plates generally augmented; the degree of alcalescence is decreased.

Leucocytosis usually appears as a secondary associated sign of other diseased processes. Thus it may be observed in anæmia, further in all acute and chronic inflammatory affections, as peritonitis, pleuritis, meningitis, then in rheumatism, pneumonia, erysipelas, scarlatina and other infectious diseases, and, finally, especially frequently in tuberculosis.

No general rule has as yet been set forth with regard to the appearance of leucocytosis. For example, in some cases of pneumonia an increase of leucocytosis may be observed, while in others the number is normal. The fever is of itself no infallible means of measurement, though in some diseases, as acute and chronic tuberculosis, a simultaneous rising and sinking of the temperature curve and the number of leucocytes has been noted. That a swelling or enlargement of the spleen or lymph-glands does not necessarily cause leucocytosis is best proved by

pseudo-leukæmia. However, such an apparent connection has not rarely been noticed.

Usually, though not by any means always, we find with leucocytosis the number of red corpuscles more or less decreased, so that an acute augmentation of leucocytes by relative increase appears to be still greater. The procental relation of the different forms of leucocytes may move within the normal boundaries, yet not infrequently one notes that the number of mononucleated large and small cells sinks below the normal. Thus there are cases where the crenated and polynucleated leucocytes rise to 95 per cent.; but the contrary never occurs, *i.e.*, a great procental diminution of the second group. Very often the blood-plates are increased in leucocytosis.

Leukæmia may be differentiated from leucocytosis by many symptoms. As to the red blood-corpuscles, their number at the beginning of the disease is *not* diminished. Only later, when serious disturbances of nutrition have set in, anæmia is added to leukæmia, and toward the end of the disease oligocythæmia of an extreme grade is present. The quantity of hæmoglobin runs, in general, parallel with the number of the erythrocytes. At the latter end of the course the red corpuscles in both form and size gradually more and more approach the picture of grave anæmia; in some cases leukæmia seems to be complicated even with *pernicious anæmia*. The leucocytosis gradually increases during the course of the disease, and may reach excessive grades, until finally more leucocytes than red corpuscles are contained in the blood. Such a degree is never observed in leucocytosis. The procental relation of the various forms of leucocytes is usually so altered that the mononucleated small ones and the large cells are greatly diminished; not rarely a case is observed where the numerical relation is reversed, and the leucocytes form seventy-five per cent. Many cells of leukæmic blood contain eosinophile granula; neutrophile cells are usually observed in cases in which the mononucleated large leucocytes are predominantly increased. The blood-plates are generally increased. The degree of alkaliescence is decreased. After death the Charcot-Leyden crystals are found in leukæmic blood.

Pseudo-leukæmia is that disease where the same changes of the so-called hæmatopoetic organs are present, as in leukæmia, with-

out the blood offering the above-described symptoms. The number of red corpuscles and the quantity of hæmoglobin are generally reduced moderately while the number of white corpuscles is sometimes even normal. But often we meet with this picture of a leucocytosis with swelling of the spleen and multiple enlargement of the lymph-glands.

Hæmoglobinæmia, which leads to paroxysmal hæmoglobinuria, is a disease which appears usually in single attacks. If one examine the blood during an attack the plasma seems to be strikingly yellow in color; the red corpuscles, on the contrary, are strikingly pale, some being scarcely colored, and present a picture of moderate to severe extreme poikilocytosis. Among the cells one notices more or less numerous aggregations of irregular clumps of hæmoglobin. Besides this idiopathic form of hæmoglobinæmia, it is known that such a disintegration of the blood may follow poisoning by certain substances, as the chlorate of potash, arsenuretted hydrogen, naphthol, etc. Further, this symptom may be observed after burns and exposure to extreme cold; and, finally, grave infectious diseases may develop chemical agents in the blood which induce hæmoglobinæmia.

DIAGNOSIS OF DIPHTHERIA.*

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THE diagnosis of diphtheria has so long remained an uncertainty, depending upon such developments as contagion, paralysis or death, the very accidents which it is our province to avert, that any means which promise to aid in its early recognition are well worthy of our unbiased investigation. Considering the insidious onset of the disease, its infectious nature, its increasing prevalence and frightful mortality, we cannot afford to scorn the honest efforts made by painstaking bacteriologists to render in diphtheria the same certainty of diagnosis as their labors have already achieved in pulmonary tuberculosis.

* Read at the Kentucky Hom. Med. Association, May 25, 1899.

Clinically we meet with a certain number of cases which so resemble the milder forms of angina or croup that with a feeling of security we assure the patient and his friends of the benign character of the affection until, startled by a sudden development, we in humiliation are forced to acknowledge our mistake.

Pathologists all agree that the production of a pseudo-membrane depends upon the *intensity* rather than the nature of the cause; that corrosive irritants, the Klebs-Löffler bacilli or the pyogenic cocci, are capable of setting up a fibrinous inflammation, with exudation of white corpuscles, coagulation of fibrin, and death of the tissue cells. The old designations, croupous and diphtheritic membranes, are relative terms only, for the greater penetration and adherence of the latter are due simply to a greater intensity of inflammation, and the removal of a diphtheritic membrane is frequently followed by a more intensified or croupous exudate. Thus any of the above-mentioned causes may, by greater or less concentration, produce a pseudo-membrane of varied depth and consistency.

It is the consensus of all medical authority that the propagation of diphtheria depends upon the infectious properties of the Klebs-Löffler bacillus, to whose toxin the constitutional symptoms are due, and that, while other exciting causes may give rise to symptoms similar to those of diphtheria, such cases have neither the mortality nor manifest the infectiousness of this disease. There seems no better reason why a case presenting clinical symptoms of diphtheria caused by pure streptococcic infection should be diagnosed diphtheria than the same set of symptoms produced by cyanide of mercury or any other drug. The rôle the Klebs-Löffler bacillus plays in infection is no longer a matter of doubt; for not only have laboratory experiments on animals amply demonstrated, in accordance with Koch's postulates, the causative relation this bacillus sustains to pure diphtheria, but Riesmann, McFarland and Park relate the development of typical cases in man from accidental infections with pure cultures.

If to infectiousness we add a high mortality as a diagnostic evidence of diphtheria, we shall find this, too, to bear a marked relation to the presence of the Klebs-Löffler bacillus. In a series of 234 cases carefully and statistically studied by Blasi

and Russo-Travali, it was found that in 26 cases of pseudo-membranous angina due to streptococci, staphylococci, colon bacilli and pneumococci, 2 patients died, the mortality being 3.84 per cent. In 102 cases of pure diphtheria 28 died, a mortality of 27.45 per cent. Seventy-six cases showed diphtheria bacilli and staphylococci; of these, 25, or 32.89 per cent., died. Twenty cases showed the diphtheria bacilli and streptococcus pyogenes, with 6 deaths—30 per cent. In 7 cases, of which 3, or 43 per cent., were fatal, the diphtheria bacillus was in combination with streptococci and pneumococci. The most dangerous form met with were 3 cases, all fatal, in which the diphtheria bacillus was found in combination with the bacillus coli (McFarland's text-book on pathogenic bacteria). Mild as the cases without the diphtheria bacillus seem to be, it is generally admitted that the association of the Klebs-Löffler bacillus with the pyogenic cocci favors the invasion of the tissues by the latter, the patient often succumbing to the combined effect of diphtheritic toxæmia and septic infection.

The mere presence of the Klebs-Löffler bacillus should not, however, lead us to infer the existence of diphtheria, for since the surface of the body—the skin and mucous membranes—is normally infested with pathogenic germs awaiting their chance to gain, through a local injury or lowered resisting powers, a favorable access to the tissues beneath, it is not surprising that the mouth and throat, through which germ-laden air and food must pass, should even in the healthy person contain a large variety of pathogenic bacteria drawn from the most diverse sources, and that bacilli closely resembling the Klebs-Löffler type, or identical with it, should occasionally be found in these localities without giving evidence of disease. In 1894 Park and Beebe examined the throats of 330 healthy persons, in 24 of whom they found a non-virulent bacterium having the morphological and cultural characters of the Klebs-Löffler bacillus, while the virulent bacillus was found in 8 cases, 2 of which later developed the disease. In another series, examined during an epidemic in New York City by Dr. Park, about 1 per cent. presented virulent diphtheria bacilli in their throats, most of which persons were found to have been in direct contact with patients suffering with diphtheria. The results of a bacteriological examination alone should not, there-

fore, be considered decisive, but is to be regarded as a mere *adjunct* to the clinical symptoms in evidence. If, as is claimed by Dr. Park, of all pseudo-membranes containing bacilli identical in microscopical and cultural peculiarities with the Klebs-Löffler bacillus, more than 95 per cent. are found diphtheritic, the ordinary bacteriological examinations, when properly executed and taken in consideration with the presence of the membrane, will leave but a small margin for doubt, which margin may be still further reduced by inoculations into animals of pure cultures of the bacilli to ascertain their pathogenic effect.

The formation of a pseudo-membrane, especially when it takes place in the nose or larynx, is unquestionably the most important symptom of diphtheria. Of 22 cases of fibrinous rhinitis examined by Dr. Edmund Meyer, 9 contained staphylococci albi and aurei, or streptococci; while the remaining 13 presented the Klebs-Löffler bacillus. The diphtheritic membrane usually has a whitish or grayish appearance, and adheres so tightly that a little bleeding commonly occurs on its removal, which is followed, in a few hours, by the re-formation of the membrane. An extension of the exudate to the uvula or soft palate, with œdema of the surrounding tissues and enlargement of the lymphatic glands, is strongly significant. However, from this characteristic appearance the membrane occasionally presents marked deviations, sometimes appearing yellow or brownish in color, at other times merely as a light film over the mucosa, from which it is easily detached. Lymphatic glands may enlarge and necrose from absorption of the diphtheria toxin alone, but suppuration is usually due to the action of pyogenic cocci. Should the diphtheritic membrane be limited to the tonsils, which lack direct communication with the lymphatic system through excretory ducts, œdema and swelling of the cervical glands do not often appear. A plausible reason for the greater or less severity of the constitutional symptoms, aside from the variance in potency of the toxin absorbed, may be found in the *location* of the pseudo membrane, absorption taking place in proportion as the parts are more or less richly supplied with lymphatics. As diphtheria limited to the tonsils is generally mild in character, presenting but little constitutional disturbance, so a diphtheritic exudate confined to the

true vocal cords, which are especially susceptible to infection from their exposed position and comparative dryness of mucous membrane, and which are but scantily supplied with lymphatics, will produce symptoms of mechanical obstruction rather than systemic intoxication. When the membrane extends to the more vascular portions of the larynx, the constitutional symptoms of diphtheria supervene. Rarely diphtheria exists, and even death from œdema of the glottis has ensued, without the presence of a pseudo-membrane, the diagnosis being determined by the constitutional symptoms and bacteriological tests.

The systemic disturbance of diphtheria, due to absorption of diphtheria toxin, and, at times, to septic infection, is most pronounced upon the nervous system, producing degeneration of nerve fibres and peripheral paralyses, not always in proportion to the extent of the local lesion. Paralysis of the soft palate embarrassing articulation and deglutition, loss of power of the motor oculi resulting in strabismus, paræsthesia and anæsthesia of the extremities followed by paralysis of same, are the usual consecutive order of the symptoms typical of the disease. To this may be added heart failure, preceded by a very rapid or a slow and irregular pulse. Albuminuria occurs in a large proportion of cases, and sometimes appears as early as the second day, but seldom lasts longer than a week, and is rarely complicated with nephritis.

The great majority of pseudo-membranous inflammations in the adult are non-diphtheritic; and, although essentially a disease of childhood, diphtheria rarely attacks young infants.

That the disease may run a chronic course is shown by F. Jessen, who reports a case in which the clinical evidences of diphtheria persisted for more than five months; and by Dr. Meyer, who reports the case of a boy, 2 years of age, suffering from laryngeal and pharyngeal diphtheria ending fatally on the thirty-second day; also the case of a girl, 2 years old, of over two months' duration.

A case presenting an array of symptoms typical of diphtheria is easily diagnosed; but if the words of Jacobi be true, "there is as much diphtheria out of doors as indoors, as much out of bed as in bed," we cannot hope to materially check the natural progress of an epidemic by isolating only one-half of the pa-

tients while the others go unhindered, especially as it is a frequently observed fact that severe cases of diphtheria may be contracted from a person suffering with a mild attack. It is in these milder cases that only bacteriological examinations can decide the question of diagnosis and isolation. One could hardly think of subjecting every patient with pseudo-membranous angina or croup to the protracted restraint and care demanded in true diphtheria, as implied by the following results: Out of 605 cases examined by Park and Beebe to ascertain the persistency of the Klebs-Löffler bacillus in the throat after the disappearance of the pseudo-membrane, in 304 cases the bacilli had disappeared within 3 days; in 176 cases they persisted for 7 days; in 64 cases for 12 days; in 36 cases for 15 days; in 12 cases for 3 weeks; in four cases for 4 weeks; and in 2 cases for 9 weeks.

It is true that a small percentage of cases cannot, with the very best means at our command, be positively diagnosed, that many of our present methods will have to be modified or relinquished, and that reports adverse to generally accepted views may now and then be seen, but as much can be said against the diagnosis of any other disease; and when we consider the vast amount of research necessary for the establishment of a single fact in science, and the impetus progress receives thereby, we cannot but feel gratified that medical diagnosis has in bacteriology found a searchlight of increasing power which may reveal the lurking presence of a deadly foe.

OCULAR HÆMORRHAGES; SPONTANEOUS CONJUNCTIVAL HÆMORRHAGES.

—Salva had under his care a girl of 17 years of age who became the subject of spontaneous conjunctival hæmorrhages. She did not suffer from any organic lesion whatever, menstruating regularly and normally. The blood came from no particular spot, but seemed to filter through the entire face of the conjunctiva. Several cauterizations with a 10 per cent. solution of protargol, repeated three times daily, resulted in a cure after other measures had failed. Altogether, the hæmorrhages had persisted for a period of two years, during the latter part of which time they had occurred at times as frequently as every hour or two, and at night as well as by day. The author regarded them as hysterical manifestations, many other symptoms of this trouble being present. He is at a loss, however, to decide whether the cure should have been ascribed to suggestion, which failed with other methods of treatment, or to some change in the membrane that was produced by the protargol.—SALVA, Grenoble, *Annals d'Oculistique*.

Wm. Spencer, M.D.

EDITORIAL.

WM. H. BIGLER, A.M., M.D.

WM. W. VAN BAUN, M.D.

TUBERCULOSIS.

THAT the medical profession as a body is thoroughly aroused to the terrible character of the scourge of tuberculosis which annually slays its tens and hundreds of thousands in the various communities throughout the world is seen from the activity at present prevailing in its discussion, both in papers contributed to the journals and in the congresses convened for its special consideration.

That the efforts to combat the disease have been rendered more effectual by such means is proved by the diminished rate of mortality, as well as by the acknowledgment of the possibility of a cure. A diagnosis is now no longer equivalent to a sentence of death.

One of the conclusions reached at the late Berlin Congress, and emphatically maintained by Virchow, we think needs still further proof, although by saying so we lay ourselves open to the charge of being decidedly behind the times. We refer to the one that tuberculosis is not hereditary. We are not so presumptuous as to oppose our own individual opinion to this proposition, backed up as it is by such an authority as Virchow, but we are not ready at once to abandon the results of years and years of careful observation on the part of most careful observers in order to fit the facts to modern theories. We do, therefore, venture to say that this proposition is not proven.

With the rise of the germ theory of disease and the discovery of Koch's bacillus it was thought impossible for the disease to be hereditary in the old acceptance of the term, and therefore all previous observations, many of which were no doubt incomplete and faulty, were rejected. Then followed such a wrestling and distortion of later observations to prove this preconceived theory as would not have been possible in any other science laying claim to exactness. This same explanation of

facts still continues, even after the necessity for it has been removed. The possibility of the transference of disease germs from mother to offspring *in utero* having been amply demonstrated in the case of other diseases, the possibility of the same occurring in the case of tuberculosis must be acknowledged. Against this the argument advanced by Virchow "that, on the basis of pathological experience, tuberculosis is not hereditary, as it is never found in unborn or newly-born children," can have but little weight, if we compare the vast majority of cases of children dying of this disease which are not subjected to examination at the hands of skilled pathologists. No matter how vast the number of examined cases, they form but too insignificant a proportion of the whole number occurring to be used as the basis of a universal proposition. Keeping in view the *possibility* of inheritance, and that is all we claim, it will not be necessary to resort to force and illogical explanations of the occurrence of cases, both successive and simultaneous, in members of the same family, living and dying in the midst of the most varied environments. At the same time this point of view will put us more on our guard, and often enable us to recognize the symptoms of the pre-tubercular stage.

The idea of direct heredity has been supplanted by the theory of predisposition, but this needs to be more clearly defined and limited than is often done. It is a specific predisposition. Not every child of weakly or sickly parents is predisposed to tuberculosis. There is a specific something which is transmitted by tubercular parents to their offspring which renders them peculiarly susceptible to the attacks of the tubercle bacillus.

So long as this tubercle bacillus is accepted as inseparably connected with the development of tuberculosis the study of the life history of this germ affords the most promising field in which to discover the means for the prevention of this fell disease. For its cure, except in the sense of limiting its inroads in the individual, we think this line of study holds out less prospect of success. In this connection the late observations of M. Moeller are most interesting and significant. He discovered, on a certain kind of grass growing abundantly in France, a bacillus which has striking points of resemblance to the bacillus of Koch, and which has practically the same action

as that of the true tubercle bacillus. The thought is very near that it is the same germ modified by its environment. Should these investigations be confirmed we would have a ready explanation of the widespread occurrence of tuberculosis among our domestic animals, especially the cow, in whose system, in its new environment, this pseudo-bacillus might readily undergo modification so as to become the true bacillus.

Another link in this chain is the fact that cage-birds, pigeons and poultry are known to be very liable to tuberculosis, produced, as shown by recent investigations, by a bacillus of the same species as that of Koch, but of a different variety. The differences between them is supposed to be due to the difference in their respective environments and in their modes of nutrition. This capability of modification by environment and nutrition, by which their virulence and activity are influenced, which is coming more and more to be recognized as true of all germs, seems to us to be of the utmost importance in the directing of our efforts at cure. The hope of cure by germicides directly applied must ever remain a vain one, and our only resource is to seek to modify the germs by their environment so as to render them less virulent, or even innocuous, or so to modify their environment as to afford them no culture-medium for their development and propagation. This latter lies at the basis of the doctrine of the serum-therapy, and at present logically occupies the first rank in therapeutic measures. Were our knowledge of the action of drugs with reference to the changes produced by them in the tissues more complete, we could hope to produce the same result by internal medication, and we trust a time may come when this point will be reached. At present the two special objective points of investigation must be the entire life-history of the germ and of the influences which affect its modifications, and the essential character of the changes it produces in the system, not merely in regard to what we might call the gross pathological changes, but more especially with reference to the biochemical mutations resulting. We think that it will eventually be found that all abnormal conditions, the so-called functional as well as the organic, are dependent upon abnormal molecular arrangement of tissue elements—these, in turn, due to disturbances in their chemical elements.

THE NEW YORK STATE MEDICAL EXAMINATIONS.

THE results of the recent New York State medical examinations are both interesting and instructive. Their significance would be clearer had we at hand information as to the character of the questions, but as it is, the results stand as follows: Whole number of candidates presenting for examination, having fulfilled the stringent requirements of the New York law, and coming from all the various medical schools, 131. Of these, 111, or 84.73 per cent., were successful, while 20, or 15.27 per cent., were rejected. The number of failures in the several branches in which examinations were held is instructive, as bearing out our contention that the trend of medical education and enthusiasm is rather away from than towards that side of medicine which formerly constituted its chief glory. In surgery, in physiology and hygiene (taken as one branch), and in obstetrics (including, no doubt, gynæcology), the failures were only 3 in each; in chemistry, 7; in pathology and diagnosis (taken together), and in therapeutics, practice, and materia medica (also taken together), 9 each; and finally in anatomy, 12.

The large number of failures in anatomy and the small number in surgery seem to show that in the questions, at least, there was a disassociation of these two subjects once considered so closely connected. The combination of physiology and hygiene makes it impossible to judge of the exact results in each, but we are inclined to believe that hygiene carried many through who would not have made as good a showing in physiology alone. The comparatively large number of failures in those subjects which are supposed to constitute the working capital of the general practitioner, viz., pathology, diagnosis, therapeutics, practice, and materia medica, is a significantly ominous fact. One swallow does not make a summer, and we would not wish to draw any absolute conclusion from a single set of examination results, but the idea is forced upon us that this one, at least, shows that in those subjects which require thought and judgment, and not merely memory and mechanical skill, the medical instruction imparted, or, we would rather say, assimilated, has not been altogether in the direction most beneficial to the general practitioner.

GLEANINGS.

THE TREATMENT OF CHRONIC KIDNEY DISEASES.—Dr. Nestor Tirard, in speaking of chronic nephritis and granular kidney, asserts that we are able to prevent further progress by dietetic and hygienic regulation, but not to cure. On account of the tendency of such diseases to subacute inflammatory attacks—the “congestive attacks” of the English writers—he advises wearing woollen underclothing all the year through, with a woollen body-belt. These attacks tend to cause involvement of but little affected or still healthy parts of the kidneys. He sees no reason for persisting in a strictly milk diet except during the “congestive attacks,” and is by no means so rigid in forbidding albuminous foods as is the rule, but to allow one’s self to be led by the general state of the patient. As to alcohol, he would not advise breaking suddenly off from its use, for the consequent depression may be deleterious. At the same time, a little alcohol betters the appetite and digestion. In tendency to œdema he recommends mild and fluid diet, to increase secretion through the kidneys. As to medicamentous treatment, one cannot expect much from it, and, except in uræmia, we have three things towards which treatment is to be directed :

1. *Reduction of the Secretion of Urine.*—Digitalis, strophanthus, diuretin, with milk, will act as diuretics; saline purgatives. (Some English writers advise pilocarpine in small and frequently repeated doses as a diuretic.)

2. *Albuminuria.*—Astringents, of which the salts of iron act best, as they help the anæmia. (The tinct. of the chloride I have found very good.)

3. *Dropsy.*—Diaphoretics, warm baths, warm air, diuretics, as well as saline and hydrogogue cathartics, especially jalap, scammonium, sodium sulphate and the bitartrate of potash.

Pilocarpine may be of service to begin diaphoresis, which may be assisted and continued by a warm bath. There are cases where it is difficult to get a patient to sweat, and a bath provokes headache and distress. In such, one may try pilocarpine, with a care as to its action on the heart and lungs (pulmonary œdema). (The *U. S. Dispensatory* recommends this drug for œdema of the lungs.)

The treatment of contracting kidney by drugs is about wholly symptomatic. Of symptoms, continuous headache is worthy of attention. Sometimes mild laxatives act here, but generally such remedies that reduce arterial tension and dilate the peripheral vessels are required: nitroglycerin, amyl nitrite, the chloride of gold, the iodides of potash, sodium and strontium, mannitol, erythrol, and with an eye on the diet, *i.e.*, no nitrogenous foods.

Sleeplessness is another symptom which is frequently associated with headaches or neuralgias of an irregular distribution. At times such patients will get to sleep from a warm foot-bath at bedtime or from packing the feet in warm wrappings. If necessary, *opium* in its various forms may be used, or

small doses of hyoscin cautiously administered. *Sulphonal* and *paraldehyd* are also praised. With sulphonal the doses may be successively decreased as sleep follows. (I hold that this drug is an irritant to the kidneys. It is, after continuous use, even in such a dose as five to ten grains nightly, capable of bringing about a destruction of the erythrocytes, and a consequent hæmaturia, with albuminuria. The attending constipation which it produces is also not of any aid in renal diseases. I know of a case where I am inclined to think that its use for two years in neurasthenia either assisted or possibly caused a diffuse nephritis. A few years ago there were a number of publications on its effects on the kidneys, and particularly by Hammarsteen, Jolly, etc.)—*Norsk Magazin for Lægevidenskaben*, No. 5, 1899.

Frank H. Pritchard, M.D.

CHOREA MINOR, ITS NATURE AND TREATMENT.—Prof. Chr. Cram, of Copenhagen, holds that this disease is infectious, and that as to its benignness in children, this view will have to be modified. Osler (1887) has shown that out of one hundred and ten persons with chorea, 61 per cent., in two to sixteen years thereafter, were attacked by heart disease; and Wollenberg has demonstrated that endocarditis accompanies it much more frequently than is usually assumed. Gram's material consisted of twenty-four cases, observed from 1892 to 1898, and out of these, in sixteen there had preceded either tonsillitis, rheumatic fever, scarlatina or suppurative otitis. In eight there were no infectious antecedents; in four endocarditis, one dying later of endopericarditis. In seventeen there was *endocarditis*. Of these twenty-four, four died of endocarditis, and the necropsy revealed small and recent vegetations, especially on the mitral or aortic valves. *The temperature in all was found to be elevated (37.8–38.5). Therefore chorea (minor) must be regarded as an infectious disease which, as a rule, is associated with endocarditis, and the prognosis is by no means as good as is generally assumed; for a heart disease is a frequent sequel.* As to treatment, he advises rest in bed, with nutritious food, feeding with the œsophageal sound if necessary. Antipyrin or salipyrin, 0.5–1.0, three to four times a day. If it becomes subchronic, then arsenic or the bromide of potash is indicated.—*Hospitaltidende*, No. 16, 1899.

Frank H. Pritchard, M.D.

MITRAL STENOSIS AND ITS EARLY DIAGNOSIS.—Dr. Gibbes asks if it be possible to diagnose this disease prior to the appearance of the presystolic murmur. By some it has been stated that it may be suspected if the first sound be short, with an especial sense of acuteness, and by others if to this there be added a duplication of the second sound. In mitral stenosis there is a particular murmur which is best heard in a limited area, with or without a presystolic murmur. This sound consists of a prolongation of the diastole, a first short sound, which brusquely ends, followed by a reduplicated second sound. The writer has been able to detect this in one hundred and ninety-two cases auscultated in the upright position. In seventy-five there was mitral stenosis; in seventy-six this would disappear in the horizontal position, while in forty-four it would persist or be increased by this latter. In eight of these cases he has been able to follow out the development of an ordinary mitral stenosis.—*La Settimana Medica*, No. 17, 1899. [Osler says that "in the mitral area, usually to the inner side of the apex-beat, and often in a very limited region, is heard a rough, vibratory or purring murmur, which ter-

minates abruptly in the first sound. By combining auscultation and palpation the purring murmur is found to be synchronous with the thrill, and the loud shock with the first sound. This is the presystolic murmur, about the time and mode of production of which so much discussion has occurred." An unfortunate and special danger of the stage of compensation is the recurring endocarditis. Vegetations may be whipped off into the circulation, and, blocking a cerebral vessel, may cause hemiplegia or aphasia, or both. This, unfortunately, is not an uncommon sequence in women. I have such a case under treatment now. One is never certain when such emboli will not be thrown off. At one time they may lodge in the hand under the skin of the palm, and be readily seen; at another, strike into an artery of any limb, or one of an internal organ. Thus, in my case, the right radial artery was at one time occluded; at another one, an attack of hemiplegia; at still another one, of aphasia, with partial deafness, occurred at different times to complicate the case. In the last one an embolus lodged in some of the abdominal organs, with severe colic, vomiting, and intense pain for several days. At another seizure one lodged in the spleen, with vomiting, coated tongue, and intense pain low down on the left side, which persisted for several weeks. These recurrent attacks of endocarditis will recur at any and irregular intervals. Then the murmur will be particularly audible.]

Frank H. Pritchard, M.D.

ON ŒDEMA IN CHRONIC NEPHRITIS.—Dr. Oscar Reichel holds that in the œdema in chronic Bright's disease there is a slowness of absorption by the tissues, due to the retention in the body of toxic substances which are not excreted on account of insufficient renal action. To demonstrate this, he injected physiological salt-solution under the skin in patients with primary and secondary contracted kidneys, in those with stasis from heart diseases, and in persons with normal circulatory apparatuses. About fifty cems. of the solution were injected, and only nephritics, without œdema, were employed. After injection a circumscribed bulla is seen, which, successively spreading, gives rise to an œdematous infiltration of the skin. His experiments demonstrated that those with Bright's disease either absorb very slowly or, better said, do not absorb at all; for, in these subjects, while the œdema would disappear in five, six or eight days, in healthy ones it would have disappeared in a few hours, and in heart patients, or those with varices, in two to three days at the utmost.—*Norsk Magazin for Laegevidenskaben*, No. 5, 1899.

A FATAL CASE OF GANGRENE OF THE LUNG FROM A TOOTH.—Dr. War-rack relates a fatal case of gangrene of the lung, which was caused by a tooth falling into the larynx during an attempt at extraction under anæsthesia. Thirteen days after, the signs of pulmonary gangrene were pronounced, and three days still later the patient, a woman, died. The tooth was found in the left bronchus, which it had injured. The whole left lung was gangrenous, and filled with greasy and evil-smelling fluid.—*The British Medical Journal*, February 18, 1899.

Frank H. Pritchard, M.D.

FOOD ADULTERATION.—Dr. H. W. Wiley, Chief Chemist of the United States Department of Agriculture, regarding the adulteration of food, says that 90 per cent. of the articles of food and drink manufactured in this country are fraudulent.

In milk the cream is abstracted, water added, and preservatives used to keep it from souring. In butter, the substitution of lards and cotton-seed oil is common.

Lard is adulterated by mixing vegetable oils with the natural fat of the hog.

A mixture of molasses and flour moulded into berries and colored, then mingled with the genuine, is sold as high-grade coffee.

Fully 70 per cent. of the beer which is sold in this country is made of some article other than malt.

Very little pure jelly is manufactured. There also is a great amount of adulteration in the manufacture of vinegar.

Dr. Wiley said Vermont maple sugar was manufactured in Davenport, Iowa, out of brown sugar and an extract of hickory bark, and it was not deleterious. In fact, he said it was impossible for chemists to distinguish the two. The sugar was the same, and the natural ether that gave the maple sugar its flavor and distinctive quality was too infinitesimal to segregate in an analysis. The extract of hickory, he said, was about the same as the maple flavor. Peanut shells, he declared, were palmed off as ground cinnamon.

Among practices that are fraudulent, yet not injurious to health, he mentioned the sale of fish of cheap variety and grade for more expensive kinds, especially fish packed in oil. The sale of turtles in restaurants for terrapin was also a common means of defrauding the public.

The witness said that adulterations of food and drink injurious to the public health could be classed in two groups—coloring and preserving. The matter which is used mainly in restoring the natural color of green peas, Dr. Wiley declared, was sometimes salts of zinc and sometimes salts of copper, either of which is poisonous, and the use of which should not be permitted. Probably the most common chemical used as a preservative is salicylic acid. It should not be permitted, he stated, because it is injurious, especially to those who have weak stomachs. He ended his testimony regarding the subject by saying that no food which contained preservatives was fit to eat.—*Sanitarian*, June, 1899.

W. D. Carter, M.D.

GNORRHŒA.—Dr. F. C. Valentine says that the local manifestations of chronic residual posterior gonorrhœal urethritis, gonorrhœal prostatitis and gonorrhœal vesiculitis are grossly the same, differing only in detail. The examination is made by placing the patient on a sofa, lying on his back. The apex of the index finger and the bed of the nail are tightly packed with soap, and, then anointed with vaseline, the finger is gently inserted into the rectum. The other hand rests on the pubis, to steady and press down the viscera. The pulp of the finger is turned to the front of the patient and lightly outlines the prostate, but exercises not even the slightest pressure upon any part of it. If the operator desires to elicit evidence of chronic residual posterior gonorrhœa, he lets the finger glide from the prostate, and exercises pressure with increasing force in a stroking motion forward from the lowermost margin of the prostate, endeavoring with each stroke to force the postarethra against the posterior aspect of the pubis. If this is the region affected, the urine will show flakes, filaments or shreds. Microscopy of these will probably show the gonococcus. For prostatitis, the size, shape, and hardness or softness of each lobe, as well as of the isthmus, should be ascertained; lobulation or smooth-

ness should be elected, depressible points located, and prostatic juice, if any exudes, examined under the microscope for gonorrhœa.

The examination for seminal vesiculitis is done in the same manner, except that the finger is passed up the rectum further, beyond the prostate and to its sides. In health the seminal vesicles can barely be felt, if at all. When enlarged by disease they assume the shape of tensely filled little sausages. In engaging the finger as high up as possible on these bodies, by curving the finger downward and towards the centre with increasing force the seminal vesicles may be stripped of their contents.—*Monthly Cyclopædia*, June, 1899.

W. D. Carter, M.D.

VENTRO-SUSPENSION AND VENTRO-FIXATION.—N. W. Emerson (Boston) disapproves of the method usually employed to fix the uterus to the anterior abdominal wall, in that future child-bearing is apt to be a dangerous and complicated process. The uterus is fixed to the anterior abdominal wall in a condition of extreme anteversion, considerably beyond that found in the normal, so that, when pregnancy takes place, the suspending bands prevent the fundus from being carried sufficiently high and far enough backward into the abdominal cavity. As to the title, he makes the following distinction. By a ventral fixation is meant an actual attachment of the uterus to the abdominal wall proper, or, to be more particular, to the recti muscles. By a ventral suspension, an adhesion of the uterus to the peritonæum only, whereby, when it finally assumes permanently its new position, it is not literally in contact with the abdominal wall.

The field of usefulness of the first proposition is restricted, and it should never be undertaken when pregnancy is liable to follow. It is probably only indicated in cases of procidentia after the menopause.

The technique of ventro-fixation is as follows: A median incision two inches long is made, and the fundus of the uterus firmly fixed to the recti muscles by means of the usual sutures of silk-worm-gut. Before these are tied, the peritonæum from the bladder and abdominal wall below the lower angle of the wound is stitched to the anterior wall of the uterus along its entire length, obliterating the space between the anterior surface of the uterus and bladder and the lower abdominal wall. The peritonæum upon either side of the incision is then stitched about the fundus of the uterus, leaving it in contact with the recti muscles, and the rest of the wound closed in the usual way.

Ventro-suspension differs, in that the fundus uteri is fixed against the peritonæum instead of the recti muscles, the other steps of the operation being identical. After the suspension sutures are removed the fundus retracts somewhat from the abdominal wall; but instead of having one, two, or three bands of suspension, there is an anterior plane of suspension, which could be called a third or anterior broad ligament, giving the uterus a symmetrical support, and preventing a loop of intestine from engaging itself in front of the organ.

Thus far the author has used ventro-fixation for procidentia in four cases, ventro-suspension following the removal of tubes and ovaries in twelve cases, and ventro-suspension for retroversio uteri in seven cases, with most gratifying results. In no case has there been unusual discomfort from the operation, and in no case has there been bladder discomfort other than the most temporary.

Emerson prefers this procedure to Alexander's operation in that opportunity

is afforded of inspecting and removing diseased ovaries and tubes, which otherwise would be retained.—*Minneapolis Homœopathic Magazine*.

Gustave A. Van Lennep, M.D.

TECHNIQUE OF TOTAL LARYNGECTOMY.—Keen (Philadelphia) reports a case of successful extirpation of the larynx for carcinoma.

The patient, a man of 59, for a long time a missionary accustomed to open-air preaching, first noticed some five years previously, after an attack of grippe, that his voice occasionally *cracked*. This became more pronounced till about twelve months before operation, when hoarseness set in, and continued as the most annoying symptom.

Laryngoscopic examination showed a growth on the right vocal cord which was diagnosed as epithelioma; this was confirmed by a microscopic examination. Thyrotomy was first done and the growth removed by dissection, including the right arytenoid cartilage. Hæmorrhage, which was quite free, was controlled by pressure with iodoform gauze and the use of hot water. The laryngeal incision was closed entirely by catgut sutures. Recovery was uneventful, and at no time was respiration embarrassed.

Four months later there was a recurrence, the growth invading the left side. Total laryngectomy was performed. A median incision exposed the larynx, which was dissected free back to the œsophagus; then a low tracheotomy was done, the chloroform being administered through this opening by means of the tube and Hahn's cannula. The larynx was divided across, below the level of the cricoid and below the level of the beard, dissected up from the œsophagus, and removed. The epiglottis was also drawn down and taken out.

Communication between the wound and the mouth was shut off by suturing the anterior wall of the pharynx to the tissues below the hyoid bone. The upper end of the trachea was united to the skin by silk sutures, the tracheotomy opening closed, and the rest of the wound sutured with silkworm-gut, leaving an aperture for a small gauze drain. Hæmorrhage was not excessive.

In dressing the wound, an ingenious use of the body of a disinfected wooden pill-box, minus top and bottom, placed over the tracheal opening, with a few layers of gauze across it, served as a filter for the air inspired, and at the same time allowed free access to the opening, to clear it of discharges.

In both these operations the author placed the patient in the Trendelenburg position, and lays great stress on its value in all operations about the upper air passages. By its use he overcomes one of the greatest dangers of laryngectomy—that is, septic pneumonia, due to the aspiration of infected wound fluids either during or after the operation—and has been able, also, to dispense with the employment of the oft-troublesome tampon cannula. The Trendelenburg position is maintained for twenty-four hours or more after the operation, which can be conveniently done by placing a chair under the foot of the bed. For the first day or two no food is taken by the mouth, rectal alimentation being employed.

After the wound heals the tracheal opening contracts, necessitating the use of a tube at night. This patient, some seven months since his operation, is able to speak loud enough to be heard at a distance of about twenty feet.

Keen suggests that by using the Trendelenburg position, preliminary tra-

cheotomy can be done away with. The trachea can be divided transversely below the larynx, quickly stitched to the skin, and a tracheotomy tube inserted, the other steps of the operation being the same.—*Annals of Surgery.*

Gustave A. Van Lennep, M.D.

URETERO-URETERAL ANASTOMOSIS.—F. H. Markoe (New York), after calling attention to the dangers of ureteral injuries during operations in the pelvis, such as infiltrating malignant disease, dense and extensive adhesions, intra-ligamentary cysts or large myomatous tumors, records an interesting case in which anastomosis of the ureter was done for traumatism. As a matter of fact, out of over one hundred cases of operative injuries to the ureter recorded in surgical literature, it has been impossible to find one in the male sex.

The patient, a woman of 36, was operated for a large uterine fibroid. During the performance of a pan-hysterectomy in the Trendelenburg position, what was supposed to be a large vein was noticed on the antero-internal surface of the tumor, quite near the base of the right broad ligament, in company with a number of enlarged veins. These were all divided between two ligatures. After the removal of the uterus, the vagina and peritoneal flaps were closed with catgut sutures. Tauffer's observation that the ureter can be recognized, on account of its distention with urine, by a careful examination at the close of an operation, was evidently overlooked or not present. The patient made a good recovery from ether, but had complete anuria for twenty-four hours. For this reason the tumor was examined, and about an inch and a half of the ureter was found on its right surface. The abdomen was immediately reopened, and both ureters, dilated to the size of a little finger, were easily made out. Tracing them down into the pelvis, the left one was found sharply kinked by the closure of the peritoneal flaps, but not included in a ligature. By loosening the stitches, the urine was immediately discharged into the bladder. The proximal end of the other tube emptied itself of urine after the removal of the ligature, when a No. 9 woven catheter was introduced. The distal extremity was then found, about an inch in length, and traced to the bladder. Two traction sutures were passed close to the severed end of the kidney portion, and then within the lumen of the vesical stump, to emerge at two points about one-sixteenth of an inch apart on the respective sides. The free end of the catheter was then passed into the bladder and brought out through the meatus. The traction sutures were slowly tightened, so that the proximal extremity was invaginated for about an inch into the lumen of the distal portion, when they were tied. A circular continuous suture was carried around the line of junction, and, as a further precaution against leakage, the loose connective tissue and peritonæum in the neighborhood were stitched over the seat of operation. The abdomen was drained with gauze through the partially-sutured wound, as well as through the vagina. The catheter was left in place for five days, and when removed was encrusted with only a few crystals at its tip. The gauze drained a quantity of serum, which seemed to be mixed with urine, for a few days, when the abdominal sinus closed. Shortly after this, pelvic pain and fever led to the reintroduction of a drain from the abdominal wound out through the vagina. The sinus healed slowly until, at the end of a month, the abdominal portion was closed, and soon afterwards the vaginal portion.

The urine, when the case was reported, was acid, of a specific gravity of

1010, with a trace of albumin and a small amount of pus, but no casts. The author accounts for the pus by a moderate cystitis which developed soon after the operation. The method followed in making the anastomosis differs from that of Poggi in the support given the suture by the inlying catheter, which was first used by Tauffer in his circular end-to-end suture, and from that employed by Mayo Robson and Winslow, in that the distal end was not split to make room for the proximal end.—*Annals of Surgery*.

Wm. B. Van Lennep, M.D.

A METHOD OF PREPARING CATGUT (Frederick).—Dry sterilization at a temperature of 212°–220° F. is fairly effectual, but the gut is liable to be brittle in spots. Boiling in cumol is reliable, but liable to accidents which spoil the gut. The formalin is the simplest and best. He has used it for two years, and states unqualifiedly that for thorough sterility, complete tensile strength and ease of preparation, it is an ideal method. He buys of J. Elwood Lee Co., of Conshohocken, Pa., three-quarter-inch spools by the gross. These are notched on the flange with a common triangular file. The catgut is wound tight on the spool in one layer, and evenly, the ends passing over the flange of the spool in the notch; one end, longer than the other, after passing the notch, goes through the hollow barrel of the spool and is tied securely to the other shorter end, which has passed over the flange at the opposite end of the spool. Gut prepared by this method tends to contract forcibly, and must be held securely, or it will shrink and become useless. This is prevented by tying the ends securely, a single knot first and then a double one drawn taut, which is the secret of tying catgut to prevent slipping. Winding a single layer evenly prevents overlapping or crossing of one strand over another, and thus insures even hardening of the gut in the formalin, and avoids soft spots in the gut when it is boiled in water. The gut is wound on the spools raw, as it comes from the dealer. A three per cent. solution of formaldehyde in water is made by mixing one part of the formaldehyde (the original or commercial solution of formaldehyde is 40 per cent.) in thirteen parts of water, which is kept in an ordinary glass fruit-jar with a wide mouth. One solution may be used repeatedly, if corked tight. The spools of gut are immersed in the solution a varying time, according to size. Very fine gut, No. 0, should remain one hour; Nos. 1, 2 and 3, three, five and seven hours, respectively. If left too long, the gut becomes too hard and too brittle. The gut is then washed in running water carried down with rubber tubing to the bottom of a jar containing the spools of gut, and flowing over the top as long or longer than the gut remains in formalin. This may continue twenty-four hours without harm. This does not sterilize the gut, but toughens it so it can be boiled in water for fifteen minutes without spoiling it, which effects sterilization. It is then transferred with sterile forceps to sterile receptacles, such as rubber-sealing fruit-jars, and covered with clean ninety-five per cent. alcohol, containing ten per cent. of sterile glycerin.

Chromicized gut is prepared by winding the spools, as before. It is not necessary to remove the fat by immersion in ether, as formerly taught. The spools are then placed in a solution of bichromate of potassium, 1.5 grammes (23 grains); glycerin and carbolic acid, each 10 c.c. (2½ drachms), and water 1 litre (1 quart). Allow them to remain in this solution twenty-four hours. Then take out and allow to drain and dry for a few hours. Then place them in the formalin solution, and repeat the process above described. The gut

treated in this way will resist absorption about six weeks in all tissues except the peritoneum or kidneys.

The plain formalin gut will remain about one week to ten days before it is absorbed.—*American Journal of Obstetrics*, March, 1899.

George R. Southwick, M.D.

IRITIS OF NASAL ORIGIN.—Le François reports the case of a young married woman suffering from iritis and keratitis, with descemetitis. For five months previous to the attack she had not menstruated, although she was not pregnant. Vaginal examination revealed slight leucorrhœa, that was due to catarrh of the neck of the uterus.

Two months later she again consulted the author. Menstruation was well established, and the leucorrhœa had diminished greatly, but the condition of the eye was worse, pain having become a prominent feature for the first time two days before this visit. At this time the patient stated that there was a foul-smelling, muco-purulent, blood-stained material, which was discharged from the nose. This was removed, but no foreign body could be detected. Recovery of the eye commenced immediately, and in about a month's time it was practically accomplished, vision being reduced to but one-half. When seen three months later, vision had become normal. The author regards the uterine trouble as the predisposing cause, and the nasal condition as the exciting one.—LE FRANÇOIS, Cherbourg, *Recueil d' Ophthalmologie*.

THE DANGER OF SPECIFIC TREATMENT IN TABETIC ATROPHY OF THE OPTIC NERVES.—Nearly ten years ago, when De Wecker published his treatise on the *Eye*, he declared himself as being opposed to specific treatment in cases of the tabetic form of optic atrophy. He then held that this plan of treatment was not only valueless, but that it was worse than useless, as it hastened the atrophic process. To this opinion he still holds. It is his belief that *tabes dorsalis* is rarely, if ever, due to syphilis, and that even if such cases do exist, his statement in regard to the therapy is nevertheless true. He attacks the theories of Fournier and Antonelli, who consider hereditary syphilis to be one of the most frequent causes of strabismus.—DE WEECKER, Paris, *Annales d' Oculistique*.

Wm. Spencer, M.D.

EFFECT OF STRONG ELECTRIC LIGHT ON VISION.—Santos, Fernandez, discusses loss of vision due to electricity, and describes three causes: (1) The current itself. (2) Burns. (3) Light. He reports a case due to the last cause, the results of which were about the same as those due to intense light, as when studying an eclipse without proper precaution. The patient, robust but nervous, with 5 D of myopia, was suddenly exposed to intense electric light on August 22, 1896. He was a telegraph operator, and during a thunder-storm he attempted to put away his instrument, when a flash struck it while he was one and a half metres away.

When seen five days later the lids were œdematous; conjunctiva injected; cornea hazy, aqueous, turbid; pupil unmobile; lens opaque; light perception only, and tension raised.

Iris did not respond to mydriatic. Forty days afterward the pain was gone, but $V = 0$.

His thesis is that this was all due to the intense light; for if the electric current had played any part, he thinks there would have been some retinal changes visible.—*Cronica Medico-Quirurgica de la Habana*, No. 2.

Wm. Spencer, M.D.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

THE ATTITUDE OF HOMŒOPATHISTS TOWARD THE ANTITOXIN TREATMENT.—After reviewing the remarkable statistical proof of the value of the diphtheria antitoxin afforded by the recent report of the Chicago Health Department, Bodman, of London, asserts that the attitude taken up by the representatives of homœopathy toward this treatment is a matter of greater importance than appears to be realized by some. The question affects us in two ways: first, in regard to our responsibility to our patients, and, secondly, in regard to our responsibility to homœopathy. With respect to the first, we all admit that it is our duty to do the best we can for the patients who are entrusted to us, and consequently the question will arise, in a case of diphtheria, whether we ought to use antitoxin or not. In deciding this we must be guided by a comparison of the results of homœopathy alone with those of antitoxin alone, or those of antitoxin and homœopathy combined. There is no danger of this aspect of the case being lost sight of, but it is the other aspect to which especially he draws attention, namely, our attitude toward the antitoxin treatment considered in the light of our responsibility to homœopathy. It has been well said that “none but the most bigoted amongst us think that we have the monopoly of all therapeutic truth.” If we wish those who differ from us as to the value of homœopathy to lay aside bigotry and prejudice and examine our method with an unbiased mind, we must act in the same spirit toward them and their achievements. If, therefore, in introducing antitoxin treatment they have contributed something of genuine value to therapeutics, we shall only injure the cause of homœopathy if we deny to their work the appreciation due it.—*Monthly Hom. Review*, June 1, 1899.

F. Mortimer Lawrence, M.D.

THE TREATMENT OF INFLUENZA.—At a meeting of the West Counties, Therapeutical Society Dr. F. H. Bodman presented a paper on influenza. In addition to a hot bath, rest in bed and a liberal diet, his principal remedies in the early stage are bapt., gels., ver. vir. and eupat. perf.

For catarrhal cases, gels., ars., puls.

For follicular tonsillitis the chief remedy is merc. biniod. or merc. cyan.

For pneumonic symptoms ver. vir. at the commencement, followed by bry., phos., ars. iod., ant. tart., ant. ars., sanguin. Often there is a troublesome and rebellious cough with no physical signs to account for it; this may sometimes be removed by rumex, drosera, sticta or hyos.; but oftentimes nothing relieves it like small doses of codeia, gr. $\frac{1}{4}$.

For cases in which nervous symptoms are prominent the chief remedies are gels., ver. vir. and strych. nit.

For gastric symptoms ver. alb., iris vers., bapt., ars., merc. corr.; where colicky pains are marked, coloc. and diose.

For rheumatic cases bry., rhus., aetea and ac. salicyl.

For headache glonoin is often very efficacious, also ver. vir. or bell.; but if it is very severe, and for neuralgic pains, a few doses of antikamnia are most useful, and not to be refused as a palliative because not homœopathic.

As a general tonic, after the attack has subsided, no drug is so generally useful as strychnine. In some cases a preparation of quinine, as the arsenite 2x, is more suitable. The poison of influenza usually depresses the heart, so that some cardiac remedy is called for, such as dig., strophanth., or lycopus.—*Monthly Hom. Review*, June 1, 1899.

F. Mortimer Lawrence, M.D.

REMEDIES FOR HÆMOPTYSIS. — Blackwood, discussing the treatment of hæmoptysis, refers to the following remedies as those verified in his experience :

Aconite, when there has been exposure to dry, cold air. The patient is of plethoric habit, has a tendency to palpitation of the heart, burning, stinging pains in the chest, cheeks are usually flushed, pulse is excited, and there is great restlessness and anxiety and fear of death.

When the nervous symptoms predominate, aconite; when the arterial, veratrum viride.

Hamamelis proved useful in a case where constant spitting of dark blood for three weeks was associated with varicose veins of the legs and a history of painful bleeding hæmorrhoids.

Ipecac. is indicated by marked weakness, aversion to food, and great and long-continued nausea, with hæmoptysis from the slightest exertion.

Phosphorus has frequently proven itself master in the typical tall, slender individual with lively perceptions, inclined to stoop forward, with the empty, gone feeling of the whole abdomen, and tightness across the chest. The hæmorrhage is profuse, will cease for a time and then return.

Ferrum has assisted in a few weakly persons, the pale anæmic face becoming fiery red at times. Stools undigested, œdema of feet and legs; hæmoptysis better when walking slowly.

Millefolium gives gratifying results in cases of hæmoptysis due to pulmonary tuberculosis with cavities. There is a profuse flow of bright red blood, without the fever or restlessness of aconite.

Geranium maculatum in doses of ten to twenty drops every twenty or thirty minutes readily controlled hæmorrhages in the last stages of tuberculosis that had resisted every other treatment.

Arnica when there is a history of traumatism; the patient feels sore, as if bruised; there is hot face with cool body and limbs; the patient is weakly and troubled with pains in all voluntary muscles.

Belladonna in robust, plethoric individuals; the hæmorrhage comes on suddenly and is worse toward night. The blood is bright red, and there is great congestion of the chest, throbbing headache, and aggravation on movement.

Pulsatilla and crocus have both been of value in cases of vicarious menstruation.

Sulphur is valuable in cases that appear to get about well and then relapse.

China is indicated for great anæmia from loss of blood when debility is a prominent symptom. There is a sensation of great distention of the abdomen, not relieved by eructations or dejection. Another symptom is the sour stomach, associated with watery diarrhœa, worse at night, with copious night-sweats.—*Clinique*, July 15, 1899.

F. Mortimer Lawrence, M.D.

HYSTERIC DYSPESIA.—Dr. F. Cartier finds those drugs acting in exaggerate tonicity of the stomach to act well in the dyspepsia of hysteria. Ignat., nux moschata and asafoetida are important remedies in these cases.

TREATMENT OF EXAGGERATED TONICITY OF THE MUSCULAR LAYER OF THE STOMACH.—Dr. Cartier mentions the beneficial effects of hot water in a nauseated state of the stomach, and particularly in young girls after eating. *Creasote* is decidedly one of the best remedies in nervous vomiting, the vomiting of pregnancy, etc. *Cocculus* has vomiting without effort. *Ipecac.* is indeed homœopathic; *phos.* is very valuable in nausea or vomiting from anæmia and spasmodic weakness of the muscular layer; in these cases champagne renders great service. If the vomiting or nausea are due to an irritation of the mucous membrane, indigestion or catarrh of the stomach, then one would prefer *ant. crud.*, *arsenic.*, *pulsatilla*, *petrol.* and *ipecac.* Sometimes cramps may be the only symptom of irritability instead of nausea and vomiting. *Baptisia* is one of the best remedies in spasm or cramp of the œsophagus. If the cramp is of purely nervous origin, and in a man, *nux vom.* is a heroic remedy; if in a woman, replace it by *gratiola*. If with milk diet and *nux* you fail, look into the patient's history for aggravation from cold, cold weather, cold things and rheumatic antecedents. Here *bryonia* will cure where *nux* fails. *Bryonia* acts on the muscular layer: the sensations of weight, of a stone, and of sensitiveness of the organ to touch or pressure, indicate a muscular inflammation. These, clinically, are true *bryonia* dyspepsias.—*L'Art Medical*, No. 4, 1999.

Frank H. Pritchard, M.D.

TREATMENT OF ATONY OF THE STOMACH.—Dr. F. Cartier finds relaxation of the muscular coat to be most often associated with slow digestion; hypopepsia. The stomach, weak and atonic, distends from fermentation and dilates.

One of the most painful symptoms is the gas. The charcoals, both vegetable and animal, *carbo vegetabilis* and *animalis*, are indicated here, and though they do not resemble each other at all, the *carbo animalis* has a sense of hollowness and cold in the stomach. *Antimonium crud.* has a marvellous action in flatulency, especially in watery eructations, without odor. This drug is a rival of *carbo veg.*; and *nux vomica*, in passing, may be mentioned as at times giving good results.

Vertigo is, at times, the consequence of dilation of the stomach, and *rhus tox.* is the best drug here that he knows for vertigo from stomache affections and cerebral anæmia. In congestive vertigo and that of plethoric subjects it is of no service.—*Ibidem*.

DYSPESIA OF ANÆMIA.—Dr. F. Cartier warns against giving iron in chlorosis where there is great susceptibility of the stomach. In order to cure a chlorotic, one must make her digest well. Ignatia acts well in cases of chlorotic dyspepsia. *Helonias dioica* is a great remedy in anæmia, it stimula-

ting the gastric functions. China may be indicated when the anæmia comes from a loss of blood.—*L'Art Medical*, No. 4, 1899.

Frank H. Pritchard, M.D.

CALTHA PALUSTRIS IN ACUTE NEPHRITIS.—Dr. G. Bonino, of Turin, in a case of acute nephritis, in a young girl of 7 years of a scrofulous tendency, whose mother was neuropathic and her father rheumatic, and who had had the measles, observed in three days an enormous anasarca develop. No reason beyond a cold could be determined. Her urine was scanty and very albuminous. *Caltha palustris* seemed to be indicated, and two doses sufficed to cause the œdema to disappear and to cure the renal disease. The albumin disappeared, the secretion of urine increased, although two vapor baths were given daily as well.—*L'Omioptia in Italia*, vol. xxxiii. (This drug is our cowslip).

RHEUM IN DIARRHŒA.—Dr. Schier, of Mayence, Germany, was consulted with regard to a child of 15 months who was teething, restless, peevish, suffered from colic, and had from five to six evacuations daily, of a greenish color and slimy appearance. As it had persisted for six days, and the stool had a decidedly sour odor, *rheum* 2x was given. Already on the second day the passages were normal. This sour smell of the stool is very characteristic of rheum, and where found it is almost an absolute guarantee of success. It is quite often noted in children, and though rare in adults, it is clinically of value. The odor of the stools in children is worthy of investigation, in selecting remedies.—*Leipziger Populære Zeitschrift fuer Homœopathie*, Nos. 9 10, 1899.

Frank H. Pritchard, M.D.

MEDICAL DISEASES OF THE VEINS.—Dr. F. Cartier, of Paris, divides them into phlebitis, varices and varicose ulcers.

Treatment of Phlebitis.—*Hamamelis* is incontestably the best known and the most used medicine in inflammation of the veins, but it should be employed after its characteristic indications in order to succeed. Its chief indication is a characteristic distressing tension or heaviness, which follows the course of the vein affected. There is not the sense of contusion of *arnica*, nor the superficial sensitiveness of *lachesis*, nor the stinging lacerations of *apis*, nor the burning of *arsenic*. The varices are large, swollen, inflamed, and threaten to rupture. The veins appear to be separated by a very thin layer of skin, which is hot and red, threatening to break open. In venous hæmorrhages, as in hæmorrhoids especially, it acts well. In a serious case of bleeding hæmorrhoids in a young man where it did not succeed and decided acute anemia had been produced, trillium and ipecac in alternation arrested the hæmorrhage.

Pulsatilla is a rival of *hamamelis*. He states rather indefinitely that he employs it in females and where the pain follows the course of the vein.

Lachesis and other serpent poisons act well in phlebitis. There is extreme sensitiveness of the skin, so that even the weight of the bedclothes is not tolerated. Fornication is also a symptom.

Apis is characterized by œdema and lancinating pains, though *lachesis* may also be indicated in lancinating pains, but *apis* is characterized by a predominance of œdema, as in phlegmasia alba dolens.

Arsenicum is a remedy but little employed here, though when indicated it will act marvellously, and above all when there is burning pain or a burning sensation. Use 6x, 12x or 30x.

Frank H. Pritchard, M.D.

THE HAHNEMANNIAN MONTHLY.

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THE PRESENT STATUS OF THE SURGERY OF THE KIDNEY AND URETER.

BY WILLIAM B. VAN LENNEP, A.M., M.D., PHILADELPHIA.

(Chairman's Address, Bureau of Surgery, American Institute of Homœopathy, Atlantic City,
June 24, 1899.)

WITHIN the lifetime of most of those present, and during the professional career of some of our "grave and reverend" *seniors*, there has taken place a revolution in surgery, unique as regards the past and probably never to be equaled in the future. Thanks to anæsthesia and antisepsis in the broadest sense of the term, based as it has been on an increasingly precise pathology, one cavity, one organ, and one tissue after another has been invaded, until at the threshold of the Twentieth Century it would almost seem as if the modern surgeon, like the Macedonian of old, must needs vainly sigh for more worlds to conquer!

During the past few years no subject has excited a keener interest among surgeons than the operative intervention on the kidney and its outlet. When, thirty years ago, Simon removed the kidney for ureteral fistula, he also inaugurated and legitimized renal surgery. Operations on these organs had hitherto only been done by accident or mistake, and deliberate interference was prevented for more than a century by the interdiction of Hévin against incising the sound kidney. So, too, it was many years before Simon's "radical cure" was relegated to the past, and that only after the recent evolution of

ureteral operations. The same is true of Martin's nephrectomy for movable kidney, a procedure undoubtedly based on Simon's pioneer operation, but fortunately soon superseded by Hahn's more rational nephrorraphy.

With the exception of a few scattered published operations, among which should be mentioned an abdominal nephrectomy for hydronephrosis by Betts, of Philadelphia, and an occasional suggestive article, the literature of renal surgery was barren for the next decade, and it was not until 1880 that Morris performed the first successful nephrolithotomy. In contrast with these records, when I collected the literature of the surgery of the kidney and ureter for the past eighteen months, the reference volumes constituted a very respectable medical library.

Of fully equal interest with the pathologic conditions amenable to treatment are the advances in the prerequisite diagnosis and the operative technique necessary to meet the different exigencies. Thus the vertical Simon incision is used by many operators, Kammerer having *doubled* it, so to speak, in order to examine "the other kidney," that bugbear in every renal operation. König's "cross-cut," with some of its modifications, as an addition to the above, gives very satisfactory access to the kidney, and, with the proper curve, enables one to reach the ureter as well. The oblique incision, attributed to Czerny, has probably met with more favor than any other; it can be enlarged into that of Israel for exploration of the ureter, or, better, made to follow a more direct line toward or to the groin for complete ureterectomy. Abbè and Mayo Robson have extended to the kidney the principle of McBurney's muscle-splitting method for reaching the appendix. Like the latter, it has the disadvantage that unexpectedly extensive lesions or abnormalities of position necessitate an undesirable enlargement of the wound. Anatomically the plan is ideal, but in the single case in which I have practised it, I was disappointed in the difficulty of access to the kidney—an unusually high location being possibly accountable for this, although it was the right kidney, and not adherent.

The experimental work on the ureter and its extension to the human subject constitute an enormous step forward, and have reduced very largely the necessity for nephrectomy and

the persistence of fistula, by enabling this restored tube to drain and cure hydronephrotic, pyonephrotic and *leaking* kidneys. Thus, we have reports of transplantation of the proximal end for vicious attachment of the ureter to the pelvis, or after the division of a valve as first practised by Trendelenburg, or of the distal end into the pelvis as in Küster's successful case of resection for stricture (uretero-neo-pyelostomy).

Furthermore, the divided ureter has on several occasions been transplanted into the bladder with gratifying success, much along the lines of Witzel's gastrostomy (uretero-cysto-neostomy). This appears now to be the operation of election, having superseded the comparatively safe but uncertain vaginal, and the more rare rectal or urethral methods; it is easier of performance than union with the other ureter, and preferable to a double abdominal fistula to be subsequently closed by a bridge of skin.

Of equal interest are the experiments and operations to insert the ureter into the bowel (rectum, colon, etc.): (1), the revival of rectal ureterostomy by an obliquity which will prevent the usual ascending infection; (2), by preserving a sphincter, as in Maydl's ingenious transplantation for the correction of vesical exstrophy; and (3), after the isolation of a loop of small intestine to serve as a new bladder.

Even more encouraging is the promise of ureteral plastic operations:

1. The incision of stricture and the suture of the resultant and other longitudinal wounds on the principle of the pyloroplasty of Heineke-Mikulicz, or the closure of similar wounds after folding the tube on itself; both devices aiming to prevent cicatricial stenosis.

2. Transverse circular suture after complete division of the ureter, with or without support. By support is meant an inlying sound or catheter, which is removed after the suture is completed.

3. The oblique, end-to-end, uretero-ureteral anastomosis of Bouvée.

4. Invagination of the proximal into the distal portion, with or without splitting the ureter, and with or without support—the so-called “end-in-end” method.

5. Van Hook's lateral implantation.

By the more extended incisions, by the inguinal retroperitoneal route, and by sounding and catheterizing the ureter, this tube has been made accessible to exploration and operation throughout almost its whole extent. There still remains the deep pelvic portion, out of reach from the bladder, vagina or rectum, and hard to get at intraperitoneally, which may require a sacral operation—that of Kraske or some of its modifications—to give access to it.

We can, then, straighten out kinks, divide or excise strictures, remove calculi, incise valves, suture wounds, and, owing to its elasticity, implant either end of the ureter after section or shortening by loss of substance. In case such elasticity is insufficient, the bladder has been detached and carried backward or to one side, while the kidney has been drawn down and stitched to the iliac crest.

The ingenuity and skill which have evolved these operative advances have been shown in the study of diagnostic methods as well.

In the female, differentiation between the two kidneys has been rendered comparatively easy by Kelly's method of catheterizing the ureters, the logical outcome of Pawlik's indefatigable work and of the principle of Sims's and Trendelenburg's positions. By this means, or its modifications, the ureters have been sounded as well, and the kidney pelvis washed out or drained.

In the male, the ureteral cystoscope has been so perfected by Nitze, Oberländer, Otis, Brenner, Caspar and others that through it the orifices can be seen and catheterized. The complicated character of the instruments, and the experience and constant practice necessary for their successful application, will always be a drawback to their general use. Besides, data are multiplying to show that ureteral catheterism is by no means without danger, infections being so common that many experienced men deprecate its use. It is true, though, that there are many instances of immunity from infection, and toleration of an inlying instrument, even as long as twenty-three days, for example. Both the electric cystoscope and Kelly's more simple method will always be of value in enabling one to see the discharge of pus or blood from one or the other ureter, and, as has been emphasized of late, to recognize in

an ulceration about either orifice the presence of a descending tuberculosis from the corresponding kidney, or, in the œdema and congestion of the opening, ureteritis or retained pus. Kelly has also extended the use of his cystoscope to the male, introducing the instrument, like the Bigelow straight evacuator or Grünfeld's long endoscope, with the patient on his back, and inspecting the bladder in the knee-chest position.

The necessity for obtaining separate urines or of assuring one's self of the presence and condition of the other kidney is so important that all manner of devices have been tried to obtain this information. Their very multiplicity shows their inefficiency. Thus, of the operative measures, there are lumbar and abdominal exploration of the supposedly well kidney; temporary ligature of the ureter through the loin or vagina; ureteral catheterization through a suprapubic, vaginal, or perineal cystotomy; and even a suture passed around one ureter from the vagina. Of the mechanical devices might be mentioned, ureteral compression through the abdominal wall or the rectum; by forceps, or by a rubber bag filled with mercury in the bladder, etc. Another class is represented by instruments intended to catch the urine as it emerges from one or the other or both ureters; that is to say, by single or double catheters or specula. A most excellent evolution of this line of thought is the instrument of Harris working on the *water-shed* principle, the ridge dividing the bladder into two halves, each of which is drained by a suction-tube.

In a consideration of the subject of diagnosis, the Roentgen rays should not be omitted. The variability in the results of skiagraphy and fluoroscopy has been shown to be due to the difference in the composition of renal calculi; thus, the oxalate of lime stone—that of advanced life—gives the best shadow, while the “infantile calculus,” made up of urate of ammonium, and the uric-acid stone of young adults, produce little or no effect upon the plate or screen. The deep position of the kidney, particularly in the muscular or corpulent, is a further drawback, and Fenwick has attempted to overcome this by using the fluoroscope on the organ after drawing it out of the wound. The difficulties in carrying out such a plan as a routine practice are too obvious to require mention; and, besides, nephrotomy has been shown to be equally safe and more satisfactory.

Turning to the kidney itself, marked progress has been made in defining the sphere of each operative procedure and in the recognition of conditions amenable to surgical treatment. While the field of interference has been much extended, yet the tendency as regards operative destruction of the kidney is becoming decidedly more conservative; partial resections, suture of renal wounds, nephrostomy, improved nephrotomy and operations on the pelvis having reduced the necessity for nephrectomy to a very great degree.

The operative technique has been improved by the practice of drawing the kidney into or out of the wound, permitting thorough palpation and precise manipulations. The unreliable needling has given place to a complete division of the parenchyma from one end to the other of the free border, hæmorrhage being controlled by compressing the pedicle by the fingers or special forceps. The introduction of the finger will often suffice to stop the bleeding, while subsequent suture has been followed by primary union in the absence of infection. Thorough digital examination of every recess is thus made possible, with more working room and less danger of future leakage than when the pelvis is opened. Pouches in a distended kidney and pus-pockets can also be completely drained. I have in several instances found a stone by such an incision—one of considerable size, too—which it was impossible to feel in the intact kidney, even when it was drawn out of the wound. Operative steps on the pelvis or the neighboring portions of its outlet are facilitated by the same opening, supplemented at times by temporary incision at or nearer the lesion. The ureter also can be sounded with a long metallic probe or flushed with a colored fluid, such as methylene blue, to recognize its permeability.

Besides demonstrating that the ureter is patulous, flushing occasionally enables one to dislodge a stone, as I found in a case operated a year or two ago. The patient, a lad of about 18, had pain and tenderness in the loin and at a fixed point external to and a little below the umbilicus, and gave a history of intermittent attacks of renal colic. As has been pointed out by Guyon, the vesical end of the ureter was exquisitely tender when palpated through the rectum; urinalysis showed blood and pus. The kidney was drawn out and incised from end to

end; no stone could be found, but on introducing a probe into the ureter, it met with an obstruction a few inches down. The instrument could not be insinuated beyond this point, nor could the grating of a calculus be felt. Free and prolonged flushing through a small catheter dislodged a stone, after which the ureter became permeable. He made a rapid and complete recovery.

After nephrotomy, by suturing the divided halves to the external wound (nephrostomy), we have a valuable addition to the treatment of obstructive anuria, as the open kidney secretes more than a sutured one, even though ureteral drainage is re-established, and the condition of the patient usually precludes the more time-consuming procedures on the pelvis or the ureter. Infection of the exposed renal tissue appears to be rare.

Aprpos of the anuria of obstruction, which usually means that of calculous origin, it has been aptly said that an anuric is a patient living with one kidney. The second kidney may occasionally give out reflexly, but usually it has been previously diseased, and its excretion is suddenly arrested. Surgical intervention in such a condition is not only urgent, but must be carried out as rapidly as possible. Hence the operation of necessity is nephrotomy or nephrostomy, ureteral or even pelvic procedures being usually out of the question. Of course, incidental nephrolithotomy, or, if possible, an up or down "milking" of the calculus is a most desirable concomitant. As regards the organ to be attacked, the operative rule is to expose the one last presenting symptoms. Another form of anuria is that following accidental inclusion of the ureters in a ligature or suture during pelvic operations. There seems little doubt that such an occurrence is more common than is generally supposed, and the urinary stream is probably re-established in these cases by absorption or loosening of the ligature, or the kidney becomes hydronephrotic. Usually such an obstruction causes symptoms resembling renal colic, followed by a tumor, but both of the ureters may be occluded in this manner and no severe subjective symptoms result. So, too, there are cases recorded in which both ureters have been ligated or kinked, with complete anuria up to a day and a half, release or anastomosis being followed by complete restoration of function. In

view of such data, and the fact that anurics may live several days—one case, at least, living eleven days without a kidney—occlusion of the ureter gives ample time for its correction by the alert and observing surgeon.

Nephrostomy is also useful as a conservative operation in uronephrosis before the removal of inferior obstructions, and in pyonephrosis of septic origin for prolonged drainage, or as a preliminary to plastic ureteral work or nephrectomy. In tubercular pyonephrosis it has been advised only when the condition of the other kidney is unknown, or that of the patient precludes nephrectomy, as it appears that the latter operation is just as dangerous when secondary as when primary; nephrectomy is contraindicated as well in the presence of intimate adhesions between the kidney and neighboring structures, notably the abdominal vessels. Attempts at excision under these circumstances have resulted fatally as a rule, although Weir reports a successful suture of the vena cava lacerated during the separation of such adhesions. My personal experience leads me to look upon nephrostomy in renal tuberculosis with more favor, as I have met with at least two cases of complete healing and apparent cure, after a fair time-limit, by confining myself to the milder procedure. Other similar results have been reported. Judging by analogy and recalling the teachings of many surgeons regarding tubercular joints, and particularly tubercular disease of the testicle and epididymis, such a conservatism would appear reasonable in the kidney. Morris has carried out the same line of thought in localized, tubercular, renal lesions, excising in a V-shaped piece or slicing off areas of grouped miliary tubercles, or incising and curetting—*erasing*, so to speak—similar foci in a more advanced stage. Such measures also appeal to us as tubercular lesions, are notably multiple, and sooner or later it is reasonable to suppose that the same process will call for intervention in the other kidney. As against this reasoning there are many surgeons who advocate the removal of the kidney in the presence of advanced and even of isolated tubercular manifestations. Their arguments are based upon excellent clinical observations. Thus, (1) nephrectomy would appear at least to retard the development or progress of tuberculosis in the other kidney, and it is claimed that even infiltrated perinephral tissue will disappear in conse-

quence. (2) A tubercular ureter, when the patient's condition does not permit of the more extended operation necessary for its removal, may be left behind with a fair assurance that it will not produce a sinus, and that the process within it will become encapsulated or disappear by atrophy. (3) The diagnostic ulceration of the ureteral orifice already referred to, as well as other inferior lesions dependent upon a descending renal tuberculosis, have been found to improve or disappear after nephrectomy, or at least their trying subjective symptoms have done so—and most of such kidneys are not due to an ascending infection but produce descending dissemination. The keynote of success appears to be early recognition immediately followed by surgical intervention.

The much-dreaded fistula necessarily produced by nephrostomy must be treated according to good surgical principles. It may be of two varieties, purulent or urinary. In the former instance the pelvis has not been opened, or the kidney substance has been destroyed, and there is nothing to deal with but the every-day pus-pocket or a useless organ. In the latter, a rare sequela in the non-distended kidney, freshening and suture can be of no avail, as distal obstruction or dam, just such as we find after perineal section, must first be done away with. Hence, sounding, the inlying catheter, uretero-lithotomy, or the correction of strictures, bends, valves, or vicious ureteral insertion are the curative measures.

The question of exploration of the kidney with negative result has been squarely met and freely discussed, and it would seem that in this field, at last, an apparently mistaken diagnosis may be condoned, or even redound to the patient's good. Morris, in his masterly Hunterian lectures, reports forty-four cases of exploration for supposed calculus in which no stone was found, although in two instances at least it was subsequently discovered that the foreign body had been overlooked. As a matter of fact, however, in the majority of instances other morbid conditions were present which had closely *mimicked* calculus. Such, for example, as tubercular foci, and no lesion more closely simulates renal stone than kidney tuberculosis; appreciably movable, or Morris's "cinder-shifting" kidneys; abscesses, cysts, tumors, engorgement from intra- or extra-renal inflammatory products or from displacements, and ureteral ob-

struction from inflammation, malformation, pus or blood. Fortunately, in all these conditions operative correction has been followed by unmistakable relief. Among the outside sources of undoubted error which have been recently noted might be mentioned: appendicitis, gastric and duodenal ulcer, cholecystitis and gall-stone colic; intestinal tuberculosis, or malignant disease, or abscess; neighboring intestinal adhesions; aortic or coeliac aneurism; spondylitis and its cold abscess; vesical or prostatic calculus, suppurative disease and tumors; or morbid conditions in the uterus or adnexa.

“Nesting stones” may cause no end of trouble until they have *bored* out for themselves a bed or pocket, when they may remain quiescent for years. Renal calculus is thus characterized by deceptive ameliorations and by its chronicity; its duration, before operative interference was undertaken, having been found to vary at the Heidelberg clinic from two to twenty years. Nevertheless, as has been aptly said by Morris, a quiescent calculus, one known to be present, causing mild or transient symptoms, is a constant menace to the patient’s life. The same is equally true of suspected calculus—suspected from an analysis of the urine or from the more variable and uncertain local or reflected pains and aches. These may be lumbar, around the abdomen or to the umbilicus in renal stone, and classically vesical, scrotal, femoral, etc., when the ureter is approached or entered. Then there is a legion of more indefinite pains—ovarian, uterine, gastric, hepatic, etc.—which have been referred to in connection with diagnostic difficulties, and which are readily comprehended when we recall the wide anastomoses of the renal nerve supply. Less clear, perhaps, is the causation of severe nervous phenomena and occasional high flights of temperature. In either class of cases, and in fact in any renal calculus, we should apply the same principles as in bladder stone, viz., if suspected, hunt for it; if discovered, remove it at once by a procedure almost as safe to-day as modern lithotripsy. Morris by early intervention was able to reduce his mortality from 17 per cent. to 3 per cent.

The importance of not waiting, before exploring, for a complete classical picture of renal calculus—pain, hæmaturia, pus, crystals, and temporary suppression—has been illustrated by a number of cases. Thus, Dickinson removed a large stone from

the kidney when all the symptoms were vesical, but the bladder was perfectly healthy. Brook found enormous calculi in both kidneys when correcting a nephroptosis without symptoms suggesting stone. Weir operated on a patient suffering for two years with fixed lumbar pain, preceded by a long history of attacks of renal colic and the passage of gravel, whose urine, however, showed neither pus nor blood; the kidney contained 1 large and 40 smaller calculi.

Nephrotomy, or, more correctly, nephrolithotomy, is the operation of election in renal calculus. Unlike tuberculosis, this condition rarely calls for nephrectomy. Even in extensive calculous pyonephrosis, drainage is the first procedure, because, in the not infrequent presence of stone in the other kidney, nephrectomy before its removal is almost certainly fatal, but comparatively safe after this has been done. Several interesting reports have been made to illustrate this point, among them one of Kammerer's, in which a bladder stone was removed by epicystotomy, then nephrolithotomy was done on both kidneys, and finally the pyonephrotic organ was excised; Page reports a similar triple lithotomy.

The much talked of "crossed symptoms" of renal calculus, on which Thornton based his combined lumbar and abdominal operation, have also received notice, Morris and Fenwick both insisting that the teaching is erroneous; and yet, in a case reported by Twynam, the pain of a ureteral calculus was "crossed," requiring an abdominal section to correctly locate the stone. The painful kidney is usually diseased, and should be explored if only one is examined; but as one-fifth of all calculous cases are double, the painless kidney may be packed full of quiescent stones, while the painful organ contains but a small movable one. Several instances of such a condition have been reported.

In this connection it is interesting to note the literature on "hæmaturia from an apparently normal kidney." It is, after all, a rehash of functional as against organic disease—theoretical conclusions, apparently well demonstrated in some instances—showing such bleeding to be hæmophilic, angio-neurotic, traumatic from over-exertion, or even malarial in origin. Yet, in the operated cases, a lesion was mostly demonstrated and a cure resulted; for example, Cheyne's case of movable kidney

due to injury over thirteen years previously; Kammerer's, of hæmaturia and renal colic, the kidney being found apparently normal, but congested; McBurney's, in which nephrectomy was performed on account of dangerous anæmia and the microscopic examination only showed hæmorrhagic pyelitis; Rovsing's cases, (1) a kidney displaced downward, (2) twisted by tight lacing, and (3) pinched by the same cause, with congestion, thrombosis, and gangrene in spots. Groszlik's deductions, then, seem correct, when he advises that all cases of obscure renal hæmorrhage be subjected to exploration, a procedure devoid of danger, often therapeutic in arresting hæmorrhage, and still more frequently demonstrating obscure lesions that can be remedied.

It has been my good fortune to carry to a successful recovery a case not unlike those just mentioned. The patient had been the subject of hæmaturia, pure and simple, for years, until the resulting anæmia threatened life. Cystoscopy was negative, except that blood was seen to come from the right ureter and the other kidney was found to be doing its work. Exploration showed the profoundest hydræmia I have ever seen, and the lower two-thirds of the kidney enlarged and dark red, whether with blood or a new formation it was hard for me to decide. Partial resection was found impossible and nephrectomy was followed by a brilliant restoration to health, recovery being only retarded by a sinus from the silk ligatures on the pedicle. Professor P. Sharples Hall reports glandular adenoma, and the affected portions of the kidney and the pelvis full of blood.

The question of surgical intervention in renal neoplasms has received some encouragement, and in benign growths and cysts partial resections have been successfully practised. With the gloomy prospects and statistics given by such men as Sutton, Greig-Smith, Keith, Czerny, and others, which I must confess have been borne out by my own experience, it would seem as if operations for malignant disease were rarely justifiable. Urinary or even subjective symptoms are unreliable or absent, and the recognition of a palpable tumor would seem to be as hopeless a prognostic sign as in one of the pylorus. Besides perirenal infiltration, glandular involvement is a serious drawback to success, and the presence of the latter and a tumor growing

behind the kidney has been said to be indicated by pressure-varicocele on the corresponding side. Furthermore, it has been shown (1) that such patients should not be operated when under four years of age; (2) that the increased life duration after the operation does not exceed eight months; (3) that the operative mortality amounts to nearly 40 per cent.; and (4) that the prospect of ultimate cure at all ages is scarcely one in thirty. Nevertheless, these sinister data have been contradicted in several instances; among others, Abbè reports a successful nephrectomy of a $7\frac{1}{2}$ pound sarcomatous kidney in a 15-pound baby who was well five years later; Kynoch, the removal of a lemon-sized, renal adeno-sarcoma from a 16-month child without recurrence after two years; while Kammerer excised a carcinoma weighing, with the kidney, 6 pounds, together with involved glands, the patient gaining 42 pounds in weight during the subsequent five months.

In the treatment of movable kidney, too, the pendulum seems to be on the return swing toward an intelligent conservatism. It has been demonstrated beyond a doubt that many mobile kidneys cause no trouble at all, and, again, that in spite of successful fixation, nephrorrhaphy does not always accomplish its object. On the other hand, a further study of the symptoms produced by such a kidney prove that it may simulate many other conditions. Thus, aside from the classical lumbar dragging, and the characteristic tumor in every fifth woman and in those who lace tightly or whose abdominal wall has become suddenly lax, we meet with a host of referred pains and a long train of symptoms in the gastro-intestinal tract, or in the female reproductive organs. More than once I have been called upon to fasten a mobile kidney to cure symptoms which oöphorectomy or hysterectomy had not relieved; and the same statement, by the way, applies to renal calculus. Conversely, it is not until the relationship of cause and effect is demonstrated that we can expect relief to follow kidney fixation, as many have found to their chagrin and to the patient's sorrow.

Einhorn and others have done much to prove that movable kidney is often part of a general enteroptosis, the coincident neurasthenia and innumerable topoalgias of which are not benefited, but even aggravated, by operation. Dietetic and mechanical measures are here indicated, and usually prove

curative. As has just been said, every fifth woman has a movable kidney, and in but one-fifth of these does the displacement produce symptoms. Reduce this number still further by excluding those that can be cured by general treatment of the causative enteroptosis, and it would appear that Israel is right when he deprecates the tendency toward indiscriminate nephropexy.

In this connection it is interesting to note that in nearly nine out of ten symptom-producing displaced kidneys on the right side, chronic appendicitis is a complication, while a left-sided wandering organ is free from it. I have again and again observed this coincidence or causative relationship which it has been claimed is due to pressure on the superior mesenteric vein. Furthermore, as I stated two years ago, a beginning hernia will often simulate a chronic appendicitis, the symptoms of which will disappear after the application of an appropriate truss. So, too, I have seen the same treatment help to correct the supposed results of a *palpable* kidney which was a part of a general enteroptosis. Some years ago Shimwell called attention to the increased length of the mesentery present in the subjects of hernia, and proposed to remedy this at least predisposing cause by plaiting or infolding it. It is, then, reasonable to suppose that a visceral sag should produce a like predisposition. I have noticed, besides this, a fullness in the lower abdominal wall of such patients in the absence of the usual causative, intra-abdominal or mural conditions. Still stronger proof is found in the relaxation of the inguinal rings, even in the absence of hernia, which will admit one finger with ease, and sometimes even two.

Among recent observations appear several instances of the supposedly rare, congenital, true floating kidney. The organ has been successfully attached by the abdominal route, or by separating the layers of the meso-nephron. Cheyne records one case of a third movable kidney lying at the pelvic brim on the right side. I have found a loose kidney in this location, and one fast in the true pelvis, but never as a third organ.

The operative steps of nephropexy have excited considerable discussion. Of course, capsular sutures have given way to those passed through the substance of the kidney, where they do no harm, but the material used has been a problem, catgut

absorbing too quickly, while silk and silkworm-gut tear out of the organ or work out through sinuses; even silver wire has been a failure in my hands. Instead of this, Vulliet's suggestion of lassoing or harnessing the kidney to the last rib or back with the tendon of the longissimus dorsi has been successfully practised. Again, reasoning that sutures of any kind are only useful in holding the kidney in position until inflammatory adhesions fasten it definitively, a number of surgeons have followed Senn's plan of removing the fatty and scarifying the fibrous capsule, and suspending it by strips of gauze. By packing these loops and the cavity, the wound has to heal by granulation, gluing the kidney in place—the true *nephropexy* of the French—as against Hahn's *nephrorrhaphy*. I have practised combined suture and pack for years, only closing the wound when the necessary four-to-six weeks' confinement in bed, with the pelvis elevated, was out of the question.

A word concerning renal traumatism and I am done. The tendency seems to be to treat kidney lacerations or rupture expectantly, in the absence of dangerous anæmia, intraperitoneal extravasation, or tumor, and to save many kidneys or *remnants* hitherto sacrificed; for here, again, that bugbear, “the other kidney,” comes to the front. My own results have been better with secondary than with primary intervention. I have made use for several years of the inlying clamp, recently suggested by Meyer, on the principle of Péan's vaginal hysterectomy, in “hurry-up” nephrectomies, or those in which isolation of the pedicle was difficult on account of clots. A recent fatality has led me to doubt the advisability of this plan, although the clamp may not have been to blame. A pulpified kidney was removed, together with an immense hæmatoma; the clamp was taken off and a secondary suture made. When, after healing, the patient got up for the first time, he suddenly died from an embolus.

In conclusion, let me say to my fellow-members of the Institute, as I have attempted to show in this address, renal surgery lays claim to a number of lesions hitherto treated expectantly but unsuccessfully, or necessarily fatal. It lies with the general practitioner to recognize these conditions and call upon his surgical colleague in time. When, nearly ten years ago, I made my bow to this Association with the first paper on appen-

dicitis, some of my fellow-surgeons took exception to my diagnoses and aggressive suggestions; quite recently, in Buffalo, some of my fellow-practitioners related experiences to show that the knife was unnecessary. One by one we have been led by our first, second, or even third malignant case to realize the necessity for surgery; but, alas! *each* lesson to *each* practitioner costs a human life, and as I know, to my sorrow, at times the life of a beloved and admired colleague. The same is true of surgical conditions in the kidney or ureter, but with this difference, that here, instead of minutes and hours, we have days and weeks, possibly months and years. And yet even this grace is restricted when the results of early diagnosis and early operation remind us that "if it were done, then 'twere well it were done quickly."

HOMŒOPATHIC REMEDIES IN DISEASES OF THE NERVOUS SYSTEM.

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(Read before the American Institute of Homœopathy, Atlantic City, June 22, 1899.)

THE diagnosis in nervous diseases affords a rare opportunity for the display of a technical knowledge of the anatomy of the nervous system. The treatment, however, is too frequently a matter of routine statements, in which electricity, tonics and a change of climate are advised as palliating possibilities. No department in the realm of medicine has a record for more complete dodging, so far as the application of remedies is concerned. This is in part due to the fact that such diseases are characterized by a severe pathology, and often are not recognized until they are incurable. Generally, they come to us when allopathy, osteopathy and christian science have ignored and complicated the extreme pathological conditions. Again, we ourselves are guilty of attempting the heroic for fear that our milder remedies will not do, and more often the patients themselves ask for temporary relief which we dare not deny.

I fully believe that more harm is done by extreme medication and uncalled-for local remedial excess than the ravages of the average disease could possibly perform. I would not be under-

stood to underestimate the value or the necessity of local treatment, electricity, massage, or even active drug action, in many cases; yet if the law of treatment which we profess should not be applicable in diseases of the nervous system, it cannot consistently be used in the cure of other diseases. If the potency action does not avail in its influence upon the delicate and sensitive nerve cell, then it has no remedial effect at all, and we would do well to eliminate it in all scientific applications.

In the treatment of diseases of the nervous system from the standpoint of remedy utility we are confronted, first, by the pathological conditions of the disease we attempt to treat. If the tissue transformation affects parts adjacent to or involving an important part of the central or peripheral nervous structure, then our remedy applies to the functional perversion or the organic change in these parts alone. In such cases no therapeutic consideration of the nervous system is required, and therein many mistakes are avoided and many cures are performed. If, on the other hand, the pathological change or the physiological perversion pervades the nervous system directly, a neurological diagnosis commands a prescription from a neurological standpoint.

The consideration, then, naturally resolves itself into two direct questions: First, is the perversion functional or degenerative? Second, is the lesion complete or partial?

In functional diseases of the nervous system the pathological status pertains mostly to the loss of cell protoplasm and the resultant symptoms which define the neurasthenic or the hysterical condition. When neurasthenia is considered, I have found no remedy equal to or surpassing the usefulness of picric acid. That its physiological action tends to restore the lost cell protoplasm I have not the slightest doubt; this is recognized by the relief of mental irritability, by the correction of all tremors, by the restoration of conjunctival reflex, by the removal of the occipital headache and the relief of persistent pains in the cervical and lumbo-sacral regions. These symptoms pertain to the irregular discharge of nerve force and the consequent excitation of axis cylinder fibres. The loss of cell protoplasm permits this; for, in its exhausted state, the co-ordinate activity of the cell is taken away. Whether picric acid, physiologically, supplies the cell with more protoplasm (and I

believe it does), or whether its dynamic action has a tendency to stimulate and strengthen the cell function, are questions still unsettled. I am willing to say, as a result of a considerable experience, that its action certainly overcomes the neurasthenic tendency.

The symptoms of this remedy in brief may be summarized as follows: Mental prostration, with indifference; loss of conjunctival reflex; occipital pain, with cervical, lumbar and sacral irritation; fine, vibratory tremors, with heaviness and weakness of the limbs; sexual and bladder disturbances, and, with all, a general lassitude, which permits the patient to believe he suffers with a multitudinous train of symptoms, real or fancied.

When the nervous disturbance partakes more of the hysterical features—that is to say, when the inhibitory control of the nerve cell is taken away, and spasms and contractions occur—then I believe the action of picric acid should be supplemented by a remedy of a deeper action, and hence I prefer, in such cases, the combination of picric acid and zinc—*zincum picricum*—and for all practical purposes the third decimal potency is sufficiently strong. The symptoms here define a more profound cerebral depression, with conditions of hyperæsthesia, anæsthesia, neuralgia, and the spasms simulative of hysteropilepsy.

Again, when anæmia and exhaustion of the nervous system are paramount symptoms, the addition of iron to picric acid, *ferrum picricum*, is of inestimable value. It represents an extreme cell exhaustion as a result entirely of neurasthenic conditions of long standing.

The use of arsenic in diseases of the nervous system relates more particularly to a general physical exhaustion from long-continued adynamic conditions. In such cases digestive disorders, no doubt, are the fundamental perversions. Other symptoms than these, to my mind, do not call for arsenic. Its long-continued employment by the old school has been partly for tonic effect, and rarely with lasting results.

The same objection may be made to strychnia, cannabis indica, and other stereotyped remedies which give temporizing effects of a stimulative character. Valerian is a remedy of considerable value in functional disorders, and does not have

any cumulative or stimulative effect with bad reactions. I prefer it in combination with zinc, valerianate of zinc, when the neurasthenic exhaustion is quite general and the patient is of decided nervous temperament.

Phosphorus is a long-lasting remedy, and does not require frequent repetition. It is useful in functional involvement of the nervous system when blood perversions exist. Its influence upon osseous tissue is due to the fact that it restores protoplasm to the spinal cells through blood rejuvenation. Tissue necrosis is a common factor when this remedy is indicated.

Camphor is a remedy too frequently overlooked. Its action on the cerebro-spinal system should not be underestimated. Its use is more frequently indicated when spastic or convulsive symptoms predominate, and hence in hysterical and epileptoid tendencies it has a more telling effect. It has, further, a decided depressing action, and thus we find its clinical callings relate to a great depression of the general nervous system; but this is always associated with irritations of mucous surfaces, as observed in enteritis and kindred affections, acute and chronic. In insomnia it is one of my favorite remedies. I have in mind a remarkable success in the case of a patient suffering with insomnia, when the only indicative symptoms were the coldness of the limbs and cramps in the same at night. Subsultus and extreme restlessness almost always call for this remedy.

Another remedy which we frequently overlook is hypericum; not that it is so often indicated, but when it is, the symptoms are pronounced. I refer to the extreme spinal sensitiveness to touch, or even to the thought of contact. This is by no means necessarily associated with wounds or contusions, though it is beneficial when such a history prevails. So many of our spinal disorders are antedated by traumatism, that it should always be kept in mind in chronic cases of spinal irritation. Excessive pain and soreness are indications for its use.

Stannum, too, is another remedy we frequently forget. Its usefulness in catarrhal inflammations of the respiratory tract is supplemented by its favorable action in old cases of neurasthenia. The neuralgic headaches, which bother us so much in all nervous cases, and particularly those of the "coming and going" kind, yield very nicely to this remedy when given for a sufficient length of time.

In all of the foregoing remarks I have tried to give my preference in remedies for functional nervous diseases, and at the same time refer to some not so frequently thought of. I believe we always gain the best of help when a physician gives a symposium of his daily experience, and at the same time calls our attention to some remedies not so often employed. In that we add to our experience and help one another along in our professional struggle.

And now I must speak of the remedies we apply to the graver form of nervous diseases—the degenerative conditions. Here we find our greatest trouble, for the pathological feature pertains to a destruction of tissue, and this we cannot hope to repair. Myelitis we generally fail to check, but sclerosis we may correct. Here I must admit the experience of the past has only been confirmed, for the iodides are still our sheet-anchors. The iodides of arsenic, potassium, strontium, lime, baryta and calcarea are the principal ones. Their use, however, I am convinced should be in accordance with homœopathic principles and not in crude form.

Argentum nit., freshly prepared, I believe a safer and surer remedy in disseminated sclerosis than the iodides. Where specific causes complicate, I doubt if any known remedy excels the chloride of gold, continuously and persistently given in the second decimal trituration.

In my premise for discussion of this subject I stated the second diagnostic requirement was, whether the lesion was complete or incomplete. The accuracy of this is self-evident, for a complete lesion will tolerate little of our attention. The cord literally cut into by a transverse myelitis, or traversed by a progressive sclerosis, or compressed and destroyed by an organic growth, should have slight claims upon our remedies.

An incomplete lesion is always within the possibility of a cure. The pathological cause removed, the totality of the true symptoms properly observed, and the similimum of some remedy should come to our rescue. The trouble is we are too faint-hearted and fear our remedy's utility before we give it a chance. I have not touched the subject of remedies for mental conditions, nor even mentioned the graver neuroses; sufficient cannot be said of those diseases and their treatment in one short paper. That, however, the homœopathic remedy, judiciously

used in conjunction with all necessary adjuvants, will perform a greater proportion of cures than any practice of heroic medication, I have not the slightest doubt. Time will yet prove that the law of similars, faithfully adhered to, will receive its greatest exemplification in the neurological department of medicine.

HOMŒOPATHY AS RELATED TO PÆDOLOGY.

BY CHARLES MOHR, M.D., PHILADELPHIA.

(An Address given at the Meeting of the American Institute of Homœopathy at Atlantic City, June 22, 1899.)

NOTWITHSTANDING the fact that many infants and children are reared, escaping great dangers during the developmental period of life, by proper feeding and hygienic measures, no little credit is due to homœopathy in their treatment. Fortunately for the growing infant and child, many a parent has given homœopathic treatment, when medicines were needed, because the medicines are "so easy to take," even though the parent when sick prefers large doses on antipathic or allopathic principles. The lives of children that have thus been saved are beyond computing, for of late years it has been recognized, even by old-school authorities on pædiatrics, that the drugging of children is pernicious; and so laymen who *would* give medicine have used homœopathic pellets, and well-versed allopathic doctors have almost entirely depended on dietetics in their treatment of sick children.

Any unprejudiced person who will carefully study the history of homœopathy, and compare the many carefully compiled statistics of the relative value of the two schools of practice—allopathic and homœopathic—must be convinced of the superiority of the homœopathic method. Take into consideration, briefly, scarlatina, with which belladonna is inseparably connected. What homœopathist since Hahnemann's day has not found the drug curative and prophylactic in suitable cases?

Osler gives the mortality-rate in scarlet fever in hospitals and among the poorer classes as ranging from 5 to 10 per cent.

in mild epidemics to 20 or 30 per cent. in severe epidemics. What homœopathist has ever met with so great a mortality in hospitals or private practice? What say statistics? In nearly all large cities scarlet fever, as a rule readily diagnosed, must be reported under the contagious diseases regulations, and therefore credence may be placed in the figures given by health boards. Take the statistics of the years 1892-95 in nineteen of the principal cities of the United States, east and west, compiled under the supervision of Dr. David A. Strickler, of Denver, and we find that out of 27,512 cases of scarlet fever reported by old-school physicians, the deaths numbered 2378; while out of 4603 cases reported by homœopaths the deaths numbered but 229. Expressed in percentages, the allopathic mortality was 8.64, the homœopathic mortality 4.97. Dr. Geo. B. Peck, of Providence, R. I., has shown that out of 1271 cases of epidemic scarlatina the allopaths lost 127, or 9.99 per cent., while the homœopaths treated 209 cases, losing 7, or 3.30 per cent. At the same time measles prevailed, of which the allopaths treated 286 cases, with 51 deaths, or 17.83 per cent., and the homœopaths treated 106, with only 2 deaths, or 1.88 per cent. Measles is usually considered a mild disease—a mistaken notion, by the way—but why is it that the allopaths lost 17 cases to every 1 the homœopaths lost? Does not this alone show that there is danger in allopathic drugging? and, conversely, does it not show the beneficence of homœopathic prescribing?

Again, let us consider pertussis. Taken with its complications, whooping-cough must be regarded as a very fatal affection. So writes Osler. As to treatment he says: "Like other infectious disorders, it runs its course practically uninfluenced, in a majority of cases, by drugs. . . . For the paroxysmal stage, a suspiciously long list of remedies has been recommended—twenty-two in one popular text-book on therapeutics. If the disease is due, as seems probable, to a germ growing upon and irritating the bronchial mucosa, a germicidal plan of treatment seems highly rational, and persistent attempts should be made to discover a suitable remedy."

Another old-school authority has written: "Whooping-cough presents a remarkable example of the labyrinth into which physicians are led at the bedside when the nature and seat of a

disease are unknown to them. There is no remedy of any consequence, no mode of treatment, which has not, in its turn, been tried for this disease, extolled, and finally rejected." Oh! if Dr. Osler and others like him only had the courage to investigate and try the homœopathic remedies, and stop speculating as to the pathogenetic germ and what would destroy it! How different the treatment, and with what confidence the true homœopathist applies his remedies in pertussis. What Bœninghausen wrote in the preface of his work on *Whooping-Cough* is as true to-day as it was when first presented. "Fatal cases are hardly to be reckoned among the possible terminations. There must be a rare concurrence of the most unfavorable conditions, as well in the constitution of the patient as in the external influences to which he is subjected, when the disease terminates fatally. But, in such cases, death is not to be ascribed to the whooping-cough *alone*, to which only a greater or less share of this unfavorable termination, rare as it is, can be attributed; and death would probably, in such a case, have been the result, in like manner, of *any* serious disease, whatever its nature might be.

"From the sequelæ, too, so frequent and so lamentable, little is to be dreaded under the homœopathic treatment. For, on the one hand, the power and energy of the disease are broken in a few days, and, on the other, the chronic miasm which is being aroused by it (call it scrofula, psora, or what we may), and in which the roots of these sequelæ generally rest, may be speedily and surely removed by remedies which homœopathy, likewise, has in her possession.

"In all cases, however, without exception, a great and incontestable advantage of homœopathy is found in the fact that it very considerably abridges the duration of the disease, and, to speak with the utmost moderation, requires for a complete cure not so many weeks as allopathy requires months.

"We may then assert, with great confidence, under homœopathic treatment, the prognosis and termination of whooping-cough are thoroughly favorable."

Statistically, Dr. Geo. B. Peck shows that in a children's asylum under homœopathic control all of 181 children with whooping-cough recovered, while reliable allopathic statistics show a death-rate of from 3 per cent. to 15 per cent.

Of late years, especially under the fostering care of the present President of the American Institute of Homœopathy, pædology has received marked attention. And it is well that this is so; and I trust that never a session of the Institute will be held without duly considering the all-important subject of the care and treatment of children. Let me call attention to the very suggestive paper on "The Mortality of Babies," by William Moore Decker, M.D., of Buffalo, New York, presented at the last meeting of our national organization. His figures are appalling. In one year (1895), in New York State, there died 38,711 children under two years of age; and it is shown that about one-third of all deaths occur in babyhood, *i.e.*, in children under two years of age.

Can such an appalling mortality be prevented? I believe it. The criminal carelessness shown by mothers; the bad food supplied to babes when artificially fed; the heterogeneous drugs administered to babes when sick, all undoubtedly add to the causes of death in these little ones, deserving our best care and concern. How many of the 38,711 babes who died as reported by Dr. Decker, think you, ever received a homœopathic remedy? Probably not 1000 of the whole lot. Dr. Decker in concluding his paper says: "The prevention of the mortality of babes—what a grand field for humanitarian work! What a splendid opportunity for sanitation! What an opening for advanced therapeutics!" And I want to emphasize the words—*what an opening for advanced therapeutics!* Here is the splendid opportunity. Let every physician all over the land make a special study of infant and child life—indeed I would even include pre-natal life—and following such master workmen as Hahnemann, Hering, Bœnninghausen, Jeanes, Lippe, Neidhard, Dunham, Guernsey, Lilienthal, Raue, Farrington, and a host more, in a strict adherence to the principles of homœopathic prescribing when medicine is needed, raise a nation of healthy men and women.

It can be done. Again I say, study the history of our School, and profit by its literature. What method of treatment save the homœopathic could be employed in the cases of acute hydrocephalus spoken of by von Grauvogl in his masterly *Text-Book of Homœopathy*? Briefly he gives the history of a young married couple whose two children died of the disease,

although both parents were apparently healthy. Both were blondes, the husband spare, the wife of full habit, and, like many such women, was obliged to feed her babes artificially for lack of mother's milk. During successive pregnancies, *sulphur* as a nutritive remedy favoring soft tissue formation, and *calcareo phosphorica*, favoring bony development, were administered to the mother, with the most gratifying results. Only healthy children were thereafter born to this couple. Von Grauvogl writes: "This is not a solitary case, for I have pursued this method for six years in all families in which there have been hydrocephalic children, with the same good result."

At the very threshold of independent life, how often the obstetrician meets with cases of asphyxia, in which it is not only necessary to resort to mechanical treatment, but in which homœopathic medicines play no small part in bringing about a favorable result. Who has not seen the syncoptic or anæmic form of asphyxia neonatorum in which there is no sign of life, the child's body relaxed, pale and cold, just born of a debilitated mother, or of one who has lost considerable blood during parturition, and where *cinchona*, even when stimulation by heat seems nugatory, sets the life current and breath going?

Then we may have the apoplectic or hyperæmic form of asphyxia at birth. The child is large, plethoric; the labor has been long and hard, or the cord has constricted its neck, and we have before us a red, bloated, hot babe, with only occasional and spasmodic circulatory and respiratory functions. Who does not appreciate the value here of *aconite*?

Again, a case presents itself where a new-born large and fat babe is threatened with suffocation. The presence of mucus is a mechanical obstacle to respiration; the face is bloated, bluish-red; the eyes protrude; bloody froth oozes from the mouth or nose, and feeble attempts at crying are made. Remove the mucus from air passages, resort to artificial respiration, but some cases do not do well until a few doses of *ipæcacuanha* have been given.

Who of the older practitioners of homœopathy have not seen cases like the one described in a felicitous paper by Dr. Albert G. Anthony, recently read before the Medico-Chirurgical Society of Central New York at Syracuse? A little boy six years of age, with frequent recurrences of so-called "worm symp-

toms," is irritable and perverse, and subject to attacks of peculiar unrest, for which he was cruelly punished by his parents. As the child grew worse, facial hemiplegia, atonic muscles, and other evidences of trophic changes, were duly recognized by Dr. Anthony, and their import pointed out to the now sorrowing parents. Fortunately, however, homœopathy came to the youngster's assistance, and under *silica* there is a gratifying improvement, with every prospect of a complete recovery.

Again, who has not seen *silica* save a member from amputation by the surgeon's knife? A boy with a badly-treated crushed finger becomes more and more ill, irritable and obstinate, owing to the pain and fever occasioned by suppuration. The old-school surgeon says: "I must amputate that finger." "Not so," says the homœopathist; he gives him *silica*, and the finger continues a useful member.

We hear of another case like this. A male child since babyhood has recurrent attacks of asthma, followed by spasmodic cough, of several weeks' duration. He is treated for several years with anti-asthmatics and anti-spasmodics, cough syrups, etc., but grows continually worse, until the homœopathist by careful investigation traces the trouble to ascarides and finds the similar in *cina*, which is prescribed during the beginning of an attack. The paroxysm is markedly shorter and less severe, and a repetition of the same medicine a few months subsequently aborts an attack and effects a radical cure.

The homœopathic doctor is called in to see a child given up to die of capillary bronchitis. He finds the little one gasping for breath, the lips blue, the fingers blue and cold, the respirations uneven and irregular, the cough smothered on account of pain, or more especially infrequent from sheer weakness, and despite expectorants, and stimulants, and poultices, death really seems imminent. But a few doses of *antimonium tartaricum* change the picture, and comfort is insured by the removal of the poultices, and in a few days the clean and again happy babe is surely convalescent.

Case after case of like gravity, covering the whole range of the diseases affecting children, might be cited; and, if all homœopathic practitioners were to relate their experiences, the cases could be multiplied by the thousand, to substantiate the claims we make for homœopathic treatment. But even in this short

paper sufficient has been said to prove its superiority to any other medical treatment, and it seems to me the only obstacles to the universal adoption of the system of treating likes with likes in the case of children are the disbelief in the superior claims set forth in this address and the trouble and patient study that are required to prove such claims by individual experiment. And we, members of the American Institute of Homœopathy, should strive with all our might to see that a belief in our system of therapeutics is engendered and kept alive, and by honest example to induce every physician of every kind to give the system a trial.

The difficulties to be surmounted in correctly diagnosing and treating children are infinitely greater than those encountered in adult life. But long and patient observation and experience will enable one to understand aright the variety of symptoms arising in the *same* disease, but differing in individual children on account of age, environment, inherited traits, etc. When one has learned to appreciate the fact that treatment by medicines, as well as by dietetics and hygienics, must correspond more to the special group of symptoms brought about by the peculiarities of the individual and the phase of the child's development than to the special disease—when, by reason of this close study and such a knowledge of drug symptomatology as will enable one to apply the *similar* to each individual case according to the Hahnemannian rules—thousands of precious lives will be saved.

PREVENTION AND GENERAL TREATMENT OF PULMONARY TUBERCULOSIS.

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Introductory.—Pulmonary tuberculosis is the most curable of all chronic diseases. This statement may be carried even farther, and it may confidently be said that death from pulmonary tuberculosis, *per se*, is unknown. Essentially it never occurs. Deaths so credited are due to septicæmia from secondary streptococcus infection.

The post-mortem table—that court of last resort in matters medical—reveals the fact that there is evidence of healed tubercular lesions in the lungs of fully one-third of all subjects.*

Fully 80 per cent. of all cases of pulmonary tuberculosis in the incipient stage are curable. This can be stated of no other chronic disease. Bright's disease, diabetes, asthma, rheumatic arthritis, tabes spinalis, essential anæmia—no other chronic affection presents such favorable prognosis as is offered by pulmonary tuberculosis.

A statement of these facts, taken in connection with the additional fact that one-seventh of all deaths are due to streptococcus infection, of which pulmonary tuberculosis is the primary condition, renders the subject of the prevention of tuberculosis the most momentous and the most pregnant that to-day engages the attention of mankind.

And yet it seems but yesterday that the world of medicine awakened to a full realization of this fact. Now congresses for its consideration are held at frequent intervals, and the subject is being agitated by the peoples of all civilized countries.

Destruction of Bacillus-bearing Sputum.—Of proposed preventive measures, one which to-day occupies a large share of attention is the destruction of the matter expectorated by the patient, containing the specific bacillus.

While personal cleanliness and common decency would dictate that all such matter, coming from the lungs or any other part of the body of a diseased person, should be destroyed, yet it is possible to exaggerate its importance as a preventive measure. Infection by the bacillus tuberculosis takes place only in the case of those with impaired constitution and lowered equation of resistance.

The history of Brompton Hospital for Consumptives, extending over a period of thirty-seven years, shows that those who live in constant association with such patients are not especially liable to become infected. Many other facts of like character could be cited.

In order for infection to occur, the constitution of the infected subject must first become impaired.

And yet, notwithstanding this fact, it is well enough to de-

* West puts the proportion as high as 60 per cent.

stroy all bacillus-bearing matter, in order to lessen the number of foci of infection.

The methods of accomplishing this are simple, and so familiar to all that I need not go into detail. Suffice it to say that all expectorated matter should be received in some disinfectant solution and at once destroyed.

The fine spray coming from the lungs of the patient when coughing is even more actively infectious than is dried sputum. This fact would teach that the mouth should always be covered by a handkerchief when in the act of coughing. But to require the patient to wear a mask for this purpose—as recommended by some—is, I think, carrying the matter to a degree of refinement bordering upon the sensational.

By these remarks I would not be understood as discouraging the destruction of the bacillus-bearing matter that comes from the patient. This should be done. The bacillus tuberculosis is not ubiquitous, excepting as persons suffering from the disease may be so. In the absence of culture and regeneration in the animal body the bacillus perishes. It has no spores to remain dormant for an indefinite period. In sputum subjected to sunlight the bacilli are quickly destroyed. In matter subjected to putrefaction all bacilli are destroyed in from six to seven weeks. In desiccated matter, not subjected to sunlight, destruction takes place in from six to ten months.

Hence it may be said that any district or locality once free from the presence of animals—man or the lower—infected with tuberculosis, and in which there is no new importation for a period of one year, is then free from the presence of the bacillus tuberculosis.

This indicates the place occupied by the destruction of the sputum as a prophylactic measure, but it must always be considered in connection with the part borne by the constitution of the individual.

The Patient.—All considerations of the prevention of pulmonary tuberculosis must, in the last analysis, deal with the constitution of the individual.

After all has been said of the infective agent—the specific bacillus—it would be a harmless guest in the lungs but for that peculiarity of the host which we are in the habit of calling “susceptibility,” but which, for purposes of this discussion, I shall refer to as *low equation of resistance*.

It can be stated, without dispute, that no human being goes through life without repeatedly harboring in his lungs myriads of tubercle bacilli. But, being received on the pulmonary mucous membrane of one who has a high equation of resistance (commonly called "inhospitable soil"), they find no culture-medium, and at once perish. This takes place in about two-thirds of all members of the human race.

In still other subjects, at some time, owing to a temporarily lowered equation of resistance, the bacilli which enter the lungs find a favorable culture-medium, and the usual changes take place. But before the process is far advanced, and before secondary infection occurs, the tubercular mass undergoes fibroid or calcareous degeneration, and recovery follows. At the end of life, with death from some other cause, these signs of former lesions are discovered. About one-third of the members of the human race are thus affected.

In still other cases the primary invasion is soon followed by secondary streptococcus infection, extensive destruction of lung tissue, septicæmia, and the usual fatal result.

About one-seventh* of the race succumb to this disease process.

Therefore, in accordance with this account, with reference to the susceptibility to invasion and infection of the lungs by the bacillus tuberculosis, the members of the human race may be divided into three classes:

1. Those whose equation of resistance is permanently maintained so high that the bacillus tuberculosis at once perishes when lodged on the pulmonary mucous membrane. PROPORTION: *About two-thirds.*

2. Those whose equation of resistance is temporarily lowered, so that infection by the bacillus tuberculosis at some time occurs, but permanent recovery, as a rule, follows. PROPORTION: *About one-third.*

3. Those whose equation of resistance is permanently lowered, so that the bacillus tuberculosis finds in the tissues of the lungs a favorable culture-medium, on lodgment the formation of colonies takes place, tubercles form, there is solution of con-

* The fractions used— $\frac{2}{3}$, $\frac{1}{3}$, $\frac{1}{7}$ —are, of course, impossible, but the saving clause is found in the qualifying adverb "about."

tinuity of lung tissue, secondary streptococcus infection, and as a result of septicæmia, due to this state of mixed infection, the patient dies. PROPORTION: *About* one-seventh.

It is in this third class that our efforts at prevention must be applied and exerted.

Those in Class 1 are removed from present consideration, because they are never affected.

Those in Class 2 call for little consideration, for in most instances the disease passes unsuspected and undetected. In others, cure is easily effected.

Hence, it is among the members of Class 3 that our victories must be achieved.

Let us for a moment consider the characteristics of these three classes.

Class 1 comprises the ordinary healthy individual, what might be called "selected risks," with full lung power, according to stature and weight, with good digestion, unimpaired nutrition, and firm of fibre. They have a high equation of resistance.

Class 2 comprises those who possess the qualities of the members of Class 1, but in less degree, so that, owing to temporarily acting influences, their equation of resistance for a time becomes lowered, but again returns to the point of safety.

Class 3 comprises those whose equation of resistance is so low that, once infected, the disease process is rapid, secondary infection is early, and a fatal result almost invariably occurs.

This class I would designate as being the "submerged seventh" of the human race. As the lower animals neglect the sick and helpless of their kind, as savage tribes destroy the infirm, the crippled and the deformed, so the *bacillus tuberculosis* is the great exterminator of the weaklings of our race. It destroys more than war, pestilence, and famine. And yet it seems to be but yesterday that the medical profession awakened to the fact that our science has it in its power to overcome this destroyer, and rescue from its onslaughts the submerged seventh of mankind.

The members of Class 3, the submerged seventh, comprise those whose "vital capacity," according to Hutchinson's tables, is below the standard that should be possessed by the individ-

ual; also those whose "corpulence," as described in Dr. Goodno's very instructive paper, to which we have just listened, is below the standard of 26. There is, in these subjects, want of full powers of digestion, and a soft "fibre," as related to the quality of the tissues.

Bodily figure and conformity of chest are significant in diagnosis, but they bear no *primary* relation to etiology. The patient does not contract pulmonary tuberculosis because the chest is thin and narrow; he has a thin and narrow chest because of the nutritive defect in the tissue-cells of the entire body, which forbid the development of a full and rounded chest.

Hence, in the last analysis, the disease is one of defective nutrition of the tissue-cells. If physiological chemistry had penetrated so far, it would show it to be in the cell-nucleus, that part richest in iron and phosphorus; that part, the function of which is to take from the blood the elements to be synchronized into formed matter. Hence it is that, in the prophylaxis of this disease, questions of food and digestion are given like distinction to those of air and breathing. Upon the integrity of the digestive process depends the proper supply of serum-albumin, serum-globulin, and fibrinogen; upon the integrity of the respiratory process depends the proper supply of hemoglobin, all of which are essential to perfect nutrition.

Hence, all treatment of this disease, including the attention given to the lungs, is not for the purpose of dislodging the bacillus. This cannot be done. It is in order to improve the nutrition of the tissue-cells of the entire body, including those of the lungs, so that their equation of resistance shall be raised, that the bacillus may perish.

In homely phrase, it is to create an "inhospitable" soil; it is to replace the culture medium upon which the bacillus is flourishing by one having such equation of resistance that it perishes.

The so-called "phthisical" subject, the one who is supposed to be "predisposed," or "susceptible," or, as I would put it, with *low equation of resistance*, has always been described as being of leuco-phlegmatic temperament, of long and narrow chest, of fair skin, with prominent blue veins. But there are a great many victims among the submerged seventh who do

not correspond to this type. Those who, in previous good health, become tuberculous following attacks of measles, of whooping-cough, of epidemic influenza, and like affections, do not all conform to the type. Nor do those whose equation of resistance is the terminal event of Bright's, diabetes, and other chronic diseases.

If powers of analysis reached so far, we should find the essential seat of this disease in the nutritive processes of the individual tissue-cells of the body. Pulmonary tuberculosis is not a disease of the lungs. It is a constitutional disease—a diathetic disease—in which the lungs are the primary organs affected, because they are constantly exposed to the invasion of the air-laden specific bacillus.

In this connection I would pause for a moment to remind you that the medicinal agents which we find most useful in tuberculosis—calcareo, kali carb., phosphorus, iodine and the iodides—are such as have a special action on cell-nutrition.

Equation of Resistance.—By the term “equation of resistance” I mean what is commonly referred to as “susceptibility,” which, however, I think is ambiguous, and fails to convey the full meaning intended to be expressed. Therefore, for purposes of convenience, I would introduce this new term.

Let us suppose that in those persons who go through life and are never affected with tuberculosis, the first term of the equation* of resistance is 100, or maintained near 100.

In those who at some time in their lives become affected, but make recovery, the first term of the equation is in the neighborhood of 50. If the equation of resistance falls temporarily to 49, or below, the ever-present bacillus at once begins to generate, the tissues yield, tubercles are formed, and the disease process is initiated. But, owing to inherent powers or the changed influences of environment, the equation of resistance is again raised to 51 or higher, and recovery follows.

In still others, the first term of the equation of resistance is primarily below 50. According to the rapidity with which the disease process progresses, it may be expressed as being 40, 30, 20, or, in the victims of acute pneumonic phthisis, it may be placed at zero (0).

* The equation would be: $100 : 100 :: R : t.$ b. (100 is to 100 as the individual resistance is to the action of the bacillus tuberculosis).

It is needless to say that this is purely arbitrary and artificial. I introduce it solely for the purpose of convenience of expression, in order to promote a mutual understanding in the use of the term "equation of resistance."

Heredity.—That pulmonary tuberculosis is not an inherited malady is in accordance with prevailing doctrines. In Heubner's clinic (Berlin) of 800 infants, not one was found to be tuberculous. Virchow says that there is no well-authenticated case of hereditary transmission. Pfeiffer (Berlin) says that in all cases of supposed congenital tuberculosis there has been found tuberculosis of the genital organs of the mother.

We may, therefore, accept it as an established fact that tuberculosis is not transmitted from parent to offspring.

But the story does not end here. We know that the tuberculous may and do endow their offspring with a defective constitution, having a low equation of resistance. This is what is inherited. This is the legacy transmitted from parent to child. The actual infection may take place in the hour of birth, or thirty years later, but the mark of the bacillus is there.

But there is still another lesson for us. Offspring with low equation of resistance to tuberculosis do not come alone from parents who are themselves tuberculous. The progeny of the aged, the progeny of the syphilitic, and of others having impaired constitutions at the time of begetting and bearing offspring, are equally prone to become tuberculous, as are those who come of strictly tuberculous parentage. What is transmitted in all cases is an impaired constitution—the constitution with a low equation of resistance.

Therefore, the prevention of pulmonary tuberculosis, as related to the subject of heredity, must have to do with the parent. In application it demands that those who are tuberculous must not marry; or, if already married, they must remain childless.

This is the problem presented to us. How shall we meet it? The State can render no aid. The law cannot interfere to prevent marriage between those of sound mind, whatever the state of the body may be. Such interference is an invasion of private rights which the citizen would not tolerate. It is a power not granted to governments.

Therefore, upon the medical profession is thrown the re-

sponsibility for the application of this important preventive measure.

In order to accomplish this, the members of the medical profession, in a systematic manner, and by united effort, must institute and carry out a propaganda of education on the subject. In this way there must be created an intelligent public sentiment which shall result in the prevention of marriage between those who are tuberculous, or others whose progeny would inherit a low equation of resistance to infection by the bacillus.

This method, it seems to me, offers the only solution to this part of our problem. In carrying it out, there should be prepared appropriate literature, setting forth the subject in clear and convincing style. This matter should be universally disseminated. This is a field in which the public press may legitimately be called upon to aid. The end and aim of this propaganda of education should be to bear home to the minds of the people of the entire world the fact that consumptives cannot safely marry; that a violation of this hygienic law will visit a dire disease upon the first generation, and there will be no third or fourth.

So far as my vision penetrates, the method that I have here outlined is the only one which will accomplish this part of our purpose—the prevention of pulmonary tuberculosis by hereditary transmission of an impaired constitution, with low equation of resistance.

Alimentation.—Pulmonary tuberculosis is a diathetic disease. In the last analysis, the defect is in the nutritive processes of the tissue-cells.

It is this fact that gives to the subject of diet its great importance. The patient who can ingest, digest and assimilate the greatest quantity of nutritious food, is the one who will make most rapid progress towards recovery. Gain in weight or loss of weight are the most reliable indices of improvement or of failure.

In this disease, when there is present severe gastric disturbance, yet there are no lesions of the stomach, not even a gastro-enteric catarrh. On post-mortem the mucous membrane is found to be in a perfectly normal condition, notwithstanding the many symptoms of dyspepsia present during life.

The gastric irritation is due to the presence of toxins in the blood. Anorexia is secondary to this.

Therefore, having a stomach not organically affected, it is possible to treat the patient by

Forced Feeding.—Regardless of the anorexia, the patient should, so to speak, be “stuffed.” He should be made to take as large a quantity of nutritious food as he can possibly dispose of.

But this measure should be intelligently carried out, else one’s zeal will defeat one’s efforts.

The diet should consist of food containing a large proportion of nutritive material. Especially should it be rich in fats. These should be in the form of butter, cream and milk (unskimmed). For those who can take it, a diet made up largely of milk should be given. Red meats—especially beef and mutton—should be freely taken. This diet should have a due proportion of fruits and vegetables, to supply the starches and phosphates. Concentrated foods should not be too much relied upon. Like Private Mulvaney, what the patient wants is “bulk on his insides.”

But in giving this diet, its intelligent administration is of the utmost importance.

The stomach must never be overloaded. A practical method is to give six meals a day, after the manner recommended by Dr. R. W. Wilcox,* of New York. This method, in detail, is as follows: If the patient suffers from night-sweats, let him be awakened at four o’clock in the morning, or at whatever hour the sweat is apt to occur, and be given a glass of warm milk. At seven o’clock the patient receives another glass of milk. At nine o’clock breakfast, with a wholesome variety of nutritious food. At eleven o’clock a light luncheon. At one o’clock a liberal dinner. At five o’clock a light tea. At seven o’clock supper, and at bedtime a glass of warm milk.

Some such method as this, varied to suit the requirements of each case, will fulfill the conditions and accomplish results which are but partially attained by artificial foods or by stomach-tube feeding, after the method of Debove.

In pulmonary tuberculosis the matter of diet is second only

* *Medical News*, May 7, 1898.

in importance to fresh air. Without fresh air the forced feeding will not only fail to accomplish desired results, but it will pall upon the patient and defeat its own purpose. With fresh air the appetite will spontaneously improve, and an increased amount of food will be demanded.

Open Air.—Since Brockmann first exploited the open-air method of the treatment of phthisis this measure has never been given so great prominence as at the present time. The wonder is that it has been so slow in obtaining universal adoption. The facts in its support are so self-evident that they call for no argument in the presence of this body of physicians. It remains only to state that there is nothing that will take the place of the open-air method, and that in importance it overshadows all others.

This method means that the patient shall live in the open air twenty-four hours in the twenty-four. When impossible to do this, then as many hours as may be.

The manner of accomplishing this is the question for present consideration.

If the patient can be sent to a sanitarium in some favorable location, where he will enjoy the benefits of the Nordrach system, the problem is solved. But, for financial reasons, all cannot do this. It may be here stated that no person who has an abundance of money and sense enough to act upon a physician's advice need suffer long from tuberculosis. All can be cured. In all cases the cure of tuberculosis is a question of dollars and cents.*

On this basis, persons suffering from pulmonary tuberculosis, with reference to prognosis, may be divided into three classes:

1. *Favorable Prognosis.*—Those with an abundance of money.
2. *Doubtful Prognosis.*—Those of moderate means.
3. *Fatal Prognosis.*—Those in poverty.

The first class—the wealthy—we need not consider. Under the advice of a wise physician, recovery should take place in every case.

The third class—the poor—if they are to be made well, must be cared for by the State. And this should be done. Not as a humanitarian measure, for the benefit of the individual suf-

* This statement refers to tuberculosis, not to advanced streptococcus septicæmia.

ferer, but as a sanitary measure, to protect the community from a communicable disease.

It remains, then, to consider the great middle class, who must be treated at home. In New York State, last year (1898), 12,000 died of phthisis. How many of these ever left their homes?

The open-air treatment must be instituted as a domestic measure.

In densely populated centres this must be accomplished by setting apart for the patient a large, light, airy upper room, with carpets and upholstery removed, and the sash taken from the windows, the openings being at times protected by canvas screens. This should be the patient's sleeping-room, summer and winter. Even in the cold of winter let the windows remain open. Warmth to the body must be preserved by sufficient bedclothing, but outside air, even though of zero temperature, must be used for purposes of respiration.

Physicians would do well to combat the ancient superstition about the injurious qualities of "night air." At night, what other kind of air is there?

In sparsely settled communities, where the surroundings permit, from early spring to late fall the patient should sleep at night in a tent, or on an open balcony or veranda.

In connection with a consideration of the open-air treatment, the subject would be incomplete without mention of the benefit to be derived from the use of the bicycle. I look upon this as being one of the most valuable adjuncts to the prevention and treatment of this disease that has ever been devised. It is far superior to "health-lifts" and all other mechanical contrivances. With wide and high handle-bars there need be no contraction of the chest. In fact, the contrary effect is produced, for the slightest exertion is followed by an increased demand for oxygen, which compels chest expansion. The only precaution necessary is moderation; stop short of getting tired.

I recommend the use of the wheel to all my patients with pulmonary tuberculosis. It is the greatest of all open-air cures.

But for those who can leave their homes, the modern open-air sanitarium, where the patient receives all the benefit of the Nordrach system, is the best. It is better than the home treatment, and cure takes place in shorter time, because the patient

"makes a business" of getting well, which, in this fickle disease, so full of false promises to the patient's easily-stimulated hope, he is apt to neglect. Moreover, at a sanitarium the patient is constantly under the watchful care of the physician. This is important, for there is no more irresponsible patient than one suffering from pulmonary tuberculosis.

But, after all else has been said, it may be stated that no other method equals that of camp life.

Lung Development.—Of all single measures connected with the prophylaxis of pulmonary tuberculosis, *lung development* is the most important, for the chances of acquiring the disease are in inverse ratio to the vital capacity and the pulmonary integrity of the individual.

This fact has become one of the accepted doctrines in medicine since it was so ably set forth by Jonathan Hutchinson in 1846.

Lung development gains its importance for two reasons. One is that a properly developed lung, possessing its full vital capacity, penetrated by air in all its parts to its utmost recesses, has no unused portions, no atelectatic areas, where the bacilli tuberculosis may rest undisturbed, without contact with air, under favorable conditions for development and growth.

It has been shown by Abrams that in tranquil breathing there are small zones of collapsed lung which are revealed by fluoroscopic examination. Their location is indicated by slight haziness, or shadow. The shadow disappears on forced inspiration. These atelectatic zones are most common in the apices, the traditional seat of tuberculosis.

Of all the organs of the body connected with animal life, the lungs are the only ones which, by habit, may be functionally active in part while other parts are inactive. The stomach, the liver, the kidneys, the heart, are always functionally active in all their parts. No one portion is at times unused while the rest is active. Not so with the lungs. In tranquil breathing, as in those of sedentary life, considerable areas may be habitually thrown out of action.

This is for the reason that the lungs, unlike the other organs named, are in part under the control of volition. It is this fact, in great measure, that gives to lung development its importance. This vital organ, whose function, in part, is subject

to volition, must by volition have its functional activity developed to the utmost.

But connected with the subject of lung development there is still another consideration, of no less importance. Pulmonary tuberculosis, in its last analysis, is not a lung disease. For reasons in the nature of accident, the lungs become the primary focus of invasion. But the disease is due to a constitutional state, intimately associated with the nutrition of the ultimate cell, not alone of the lungs, but of the entire body. The low equation of resistance is not of the lungs alone, but of the cells composing all the tissues of the body. Prophylaxis demands that the nutritive condition of the cells be raised. In order that this may be done, not only must the cells be supplied with an abundance of nutritive material as a result of stomach and intestinal digestion, but, what is of equal importance in the nutritive process, there must also be an abundant supply of oxygen. In accordance with a well-known law of physiology, the greater the lung capacity, the greater the volume of air coming into contact with the lining membrane of the pulmonary alveoli, the greater will be the number of oxygen-carriers in the blood, and hence the greater the quantity of hemoglobin to take part in the nutritive processes belonging to the tissue-cells of the entire system, in order that their equation of resistance may be raised.

It is this consideration, equally with the previous one mentioned, that renders lung development in the prophylaxis of pulmonary tuberculosis of such extreme importance.

The details of the process do not belong to the subject-matter of this paper, my present object being to assign to lung development its relative place among prophylactic measures.

I will only emphasize a few important conditions.

Not only the chest, but the entire body, must be free and untrammelled by tight clothing. Above all else this means that, in the female, corsets must be discarded. In any event, tightly-laced corsets are women-killers; but more especially is this true in the case of those who are predisposed to pulmonary tuberculosis. They do much to embarrass respiration, and so not only favor the lodgment of the bacillus, but also lower the equation of resistance by decreasing the amount of hemoglobin.

The prescribed exercises should be gone through with, systematically, many times daily, always in the open air, or before an open window.

As a measure of prophylaxis, lung development is at all times of first importance. But it should be begun in early life—in childhood, when the elasticity of the ribs, cartilages and sternum are the greatest, and when the thoracic cage is most capable of expansion.

To this end, all children—not alone those with low equation of resistance, but every child that comes into the world—at the earliest possible age, should receive systematic training in deep breathing, to promote lung development and chest expansion. By this measure, more than by any other single one, can the entire race be best fortified against the results of the great exterminator.

In order that this may be done, such exercises as I have indicated should be introduced as a part of the regimen in the public schools of the entire country. This is a legitimate function of the State. In my opinion, the American Institute of Homœopathy cannot do better than to take the initiative in bringing about this reform.

If this were done, in two generations every person living would breathe with a pair of fully-developed lungs, and the object of our present deliberations—the prevention of pulmonary tuberculosis—would be in great measure accomplished.

The methods of lung gymnastics are various, and all possess merit. Naturally, I give preference to that which did so much for me when, more than twenty-five years ago, I was myself a victim of pulmonary tuberculosis.

My method consisted of regular and systematic exercise, having for its object the permanent expansion of the chest and increase of the vital capacity of the lungs. This I accomplished by developing and using all the voluntary and involuntary muscles of respiration, including the abdominal muscles, the diaphragm, the pectoral and costal, and the muscles of the neck. This method involves exercises which shall induce and make habitual abdominal, as distinct from costal, breathing.

These exercises I continued for twenty years following the two years during which recovery from the pulmonary lesion was taking place.

This should be done in all cases. Never stop the lung exercises.

Antitoxin Prophylaxis.—At this juncture I would mention the subject of antitoxin prophylaxis only to dismiss it. Koch's tuberculin has no such power. Moreover, no serum ever will have, for the reason that tuberculosis is not a disease in which one attack grants immunity. There is no such thing as immunity from this disease. Freedom from its attacks is a question of degree of equation of resistance.

The Naso-Pharynx.—A discussion of preventive measures as related to pulmonary tuberculosis would be incomplete without reference to the important part occupied by the naso-pharynx. First, if the naso-pharynx is in an unhealthy state, it becomes the avenue of entrance for the specific bacillus. It is through lesions in the mucous membranes of these parts that entrance is gained by the bacilli which, by the medium of the lymphatics, find their way to the bronchial lymph-nodes, which later break down and infect the lungs. Not alone may primary infection by the bacillus tuberculosis be introduced in this manner, but, according to Pfeiffer (Berlin), in secondary infection the avenue of entrance of the streptococcus is through the nose.

The other consideration having to do with the naso-pharynx is that it is a part of the respiratory apparatus, and, as nasal breathing is the proper physiological method, the nasal passages must be free and unobstructed.

The two facts stated convey the lesson that preventive measures in pulmonary tuberculosis involve, among other things, a healthy state of the naso-pharyngeal mucous membranes, with nasal passages free and unobstructed.

Bathing.—In the prevention of pulmonary tuberculosis, for two reasons, the skin must receive attention. By proper bathing it must be kept up to its highest state of functional activity, since it is an important emunctory of the body, and also because, in the elimination of carbonic dioxide and the absorption of oxygen, it is capable of performing one-thirtieth part of the respiratory process.

But there is another consideration. The morning cold sponge-bath to the chest is as important and salutary a measure to-day as it was fifty years ago, when first recommended by

Priessnitz. Moccucci,* by a series of interesting experiments, has demonstrated that any irritant applied to the skin of the chest at once produces acute dilatation of the lungs. This lung reflex Moccucci produced by a spray of ether applied to the surface of the skin of the chest. But I have demonstrated that cold water has an effect equally as marked as that produced by the ether spray. At once, upon its application, percussion reveals the fact that the borders of the lungs become extended in all directions. So marked is this action that the spleen-dullness may be entirely obliterated by the temporary expansion of the lungs, and the dullness belonging to the cardiac area, as well as that of the upper border of the liver, may be very much reduced.

Hence, cold bathing to the chest not only helps to give "tone" to the skin, but, by reflex, it also produces lung expansion.

Therefore, the cold sponge-bath to the chest, preferably taken each morning, must be made one of the measures to be adopted in the prophylaxis and the general treatment of pulmonary tuberculosis.

Drainage.—The dwelling-place of the person predisposed to pulmonary tuberculosis should be on a sandy, well-drained soil, with no clay or rock subsoil. The ill-effect of dampness of soil in so affecting the constitution of the individual as to bring about low equation of resistance to infection by the bacillus has been recognized ever since it was first insisted upon by Bowditch in 1853.

Massage.—As another measure to be taken advantage of in this disease, massage and manipulation of the muscles of the chest are valuable aids. Especially is this measure of great benefit in those cases in which there is already wasting of these muscles. In such cases, not only massage, but also passive exercise of the arms, in a manner to induce chest expansion, will do much for the patient.

Sunshine.—The important part taken by this great life-giver, sunshine, is another fact recognized by all. Hence, it calls for no extended discussion. So far as possible, the patient should live in the sunshine. Not only should this be so when he is

* *Riforma Med.*, 1898.

outdoors, but a solarium should be arranged so that sun-baths may be given and the surface of the entire body exposed to the direct rays of the sun. This is a valuable measure to be used in connection with the others.

Conclusion.—In this discussion I have endeavored to indicate the nature of the disease under consideration, in order properly to estimate the true relation of preventive measures. I have endeavored to show that pulmonary tuberculosis is a constitutional disease, due to impaired nutrition, intimately associated with the function of the nucleus of the tissue-cells; that this nutritive defect in the individual lowers the equation of resistance to infection by the bacillus tuberculosis. The lungs become the primary focus of infection, because their exposed position and physiological function render them most freely accessible to invasion by the specific bacillus.

Finally, I would submit: The leading topic of this paper is the *prevention* of pulmonary tuberculosis. A survey of what has been said indicates that the prevention of this disease means proper food and proper eating, proper air and proper breathing, proper cleanliness and proper bathing, proper clothing, proper dwellings, proper sunlight and proper parents.

In a word, it means everything that will promote the health and well-being of the individual. To the accomplishment of this must be brought all the resources of hygiene and sanitation known to medical science.

This is the task assigned us. It is a tremendous one. Its execution embraces the regeneration of the race. It involves the rescue from destruction of the submerged seventh of mankind.

HOW NOT TO DO IT.

BY R. E. DUDGEON, M.D., LONDON, ENGLAND.

IN his first article on the alternation of medicines, Dr. Leach said that, in his childhood, he felt few things were more provoking than when a childish disputant, who could not or would not prove his point, stuck his tongue out and said "he didn't, he didn't, he didn't." But this, barring the sticking

out of his tongue, which would rather interfere with distinct utterance, is precisely the method adopted by Dr. Leach in mature age in our present discussion, though it fails to provoke, but only amuses me. I adduced numerous passages from Hahnemann's writings showing that he recommended the occasional alternation of medicines without "qualifying conjunctives" (and I might have added greatly to the number of these examples), but Dr. Leach, being unable to prove his point, merely says, with wearisome iteration, "he didn't, he didn't, he didn't." He seems to adopt the comforting maxim of one of Wonderland Alice's wonderful characters, that when you say a thing three times, that makes it true.

I said that "antinyim," a word frequently employed by Dr. Leach in his first article, not being discoverable in any dictionary accessible to me, was probably coined by Dr. Leach himself. In his last article he substitutes for "antinyim" a different word, viz., "antonym," which he says he did not coin, and which may be a good word for aught I know, though it is not to be found in my dictionaries; but he says nothing about "antinyim," which was the word I commented on.

He says that I interpret the word "rendering" to mean "surrendering," which, of course, he knows is not true. The word I alluded to is "rendition," which Dr. Leach uses in the sense of "translation." This word "rendition," I said, is only employed on this side of the Atlantic, as far as I am aware, in the sense of "surrendering."

It is not usually considered honest or legitimate controversy to misstate the words of your opponent; and this is what Dr. Leach has done. My criticism was on the words "antinyim" and "rendition;" Dr. Leach falsely asserts that the words I commented on are "antonym" and "rendering." Dr. Leach may not practise alternation of medicines on his patients, but he is an adept at practising alteration of the words of his opponent—the unpardonable sin in literary discussion.

I stated that Dr. Leach misquoted paragraph 272 of the *Organon*, proved it by citing the text, and gave the history of the note which Dr. Leach arbitrarily tacked on to the paragraph. This, in his last sentence, he politely calls "a surfeit of jargon."

Dr. Leach shows himself to be such a slippery controversialist that I must decline to continue the discussion with him. He does not conform to the rules of the game, but hits out wildly and "below the belt." As an old and experienced hand I may take the liberty to advise him, before he again engages in medical polemics, to learn the meanings of words, to acquire the art of writing intelligible and grammatical English, to deal honestly by his opponent, to abstain from the ridiculous affectation of employing unfamiliar words when there are plenty of familiar words to be had, and to practise that courtesy which one gentleman has a right to expect from another. So equipped, he may go bald-headed into the fight and come out of it, if not with victory, at least without dishonor. With his present propensity to use words of the meaning of which he has imperfect ideas, with his habit of misrepresenting what his opponent has said, with his obvious inability to express himself in intelligible English and his want of courtesy towards his opponent, in his methods of controversy he sets an example—or, as he may prefer to say, a "paradigm"—to be avoided by any self-respecting controversialist.

As I have said, I have no intention to continue this profitless discussion, as I have no expectation of being able to convince Dr. Leach that Hahnemann counselled and practised alternation, or that Hahnemann's translators and commentators are not a set of incompetent ignoramuses and "maligners" of the Master they profess to venerate. So Dr. Leach may and probably will continue, without disturbing my equanimity, to denounce and calumniate all who refuse to accept his interpretation of Hahnemann's words and submit to his assumption of superior knowledge. For Horace tells us:

"Non missura cutem, nisi plena cruoris, hirudo."

CORONILLA VARIA IN ESSENTIAL PAROXYSMAL TACHYCARDIA.—Starr reports two cases in which, as far as medication is concerned, the results were failures. He refers to coronilla varia, a plant indigenous to Alsace, which Poulet, of France, recommended to be used in tincture of plant or powder of flower. It is a quickly acting remedy, and from reports seems to exert a beneficial influence on the paroxysms. He reports no experience with the remedy, however.—*Clinique*, July 15, 1899.

EDITORIAL.

WM. H. BIGLER, A.M., M.D.

WM. W. VAN BAUN, M.D.

MEDICINE AND SURGERY.

WHENEVER we see a barber's sign, and think of the origin of the blood-red stripes, and are reminded of the time when the barber was the surgeon and the only surgeon the barber, and the main occupation of both was to shave and to bleed, we feel that Time has amply avenged any wrong that the whilom bleeders fancied they had suffered at the hands of their employers, the haughty medical fraternity. While he has evolved out of the barber the antiseptic surgeon, he has reduced to the level of the osteopath and the Christian scientist the original priestly healer.

Not only has the surgeon broken loose from his association with the low-priced shaver and bleeder, his former partner (notwithstanding the fact that we are now having antiseptic barbers), but he has entered the field of medical science as the peer of his former superior. His ambition has waxed ever stronger, and his claims greater, until there is now hardly a province of the wide domain of medicine which he does not threaten to invade, and not an organ of the body which he hesitates to attack.

In view of the real progress made by surgery even within the last quarter of a century, as compared with the halting, unsteady, fitful advance made by medical therapeutics during a much longer period, we cannot wonder at the attitude of the former. Nor can we wonder at the fact that it is usually the favorite study at college, and the specialty which the majority of students have selected as their own before their Junior year. Apart from the fact that even the didactic part of the course on surgery holds out such definite promise of demonstration to come, the immediate results seen in the clinics are so much more brilliant, and the actual result so much more certain than anything that the medical clinics can offer, that it at once

enthuses the young man, and makes him a willing captive to its decided fascinations.

If thine eye offend thee, pluck it out; if thine hand offend thee, cut it off, seem to be special Biblical sanctions of the claims of surgery.

Natural and almost inevitable as this seems, it is not a condition which is favorable to the progress of medicine as a healing art. We do not close our eyes to the incalculable good often done by surgical means where the efforts of medicine have proved futile, but the tendency of surgery every year to claim more and more conditions as amenable only to its treatment, and the willingness of medicine calmly to yield to these claims, surely narrows the field of effort on the part of the physician. If in one of those newly claimed diseases apparent success crowns its efforts, it is taken as a proof of its superiority; if the results are unfortunate, they are ascribed to delay, and are used to emphasize the fatal procrastination of the medical attendant. In both cases the inability to cope with the disease with anything but the knife is taken as a foregone conclusion. It is this tendency to weaken the faith in the possibility of cure which we consider the unfortunate feature of the present situation, for so very many of the brilliant results of surgery can in no way be regarded as cures, but only, at best, as palliations. Where medicine has proved itself helpless, or where, from the nature of the case, it cannot hope to be successful, there surgery, or anything else which holds out a prospect of alleviation, is justifiable. Can we suppose that if surgery had been able to remove a tuberculous lung such continued efforts would still be made to discover a cure for tuberculosis? Or that, if recurrences after operation for cancer were less frequent, so many would now be searching for the cancer germ? Or, to take an analogous case, have the efforts to find a cure for diphtheria been as persistent and conscientious since the introduction of antitoxin, in spite of its numerous failures, as they were before? When surgery proves its power to palliate, medicine ceases to look for a cure.

We need, therefore, in our medical colleges, a more even balance kept between the claims of surgery and those of medicine. How can this be accomplished? Not merely by balancing the respective number of hours of teaching and of clinics,

but by equalizing what is put into those hours and clinics. Although this is no competitive race, we cannot expect surgery to halt in its advance while medicine seeks to overtake it. The same care, enthusiasm, and determination to obtain results, which are characteristic of the surgeon, should mark the medical side of our teaching. This is, however, in the latter case, a much more difficult task. The fact that malpractice in surgery is so much more easily detected and punished has a stimulating and wholesome effect upon the surgeon. He must do his best for his own sake, if not for his patient's. His operation must be a success, even if the patient dies. The physician unfortunately works constantly in the field which the surgeon occupies only after he has scored his point by his operation; but, fortunately for him, nothing but the grossest malpractice is discoverable, for he has the apparently fickle and almost unknown forces of the human organism to deal with, by means infinitely less known and certain in their action than the temper of the surgeon's blade and the strength of his antiseptic solution. The physician labors, therefore, under a two-fold disadvantage, and should, therefore, be doubly earnest. There is here no room for the half-hearted, the skeptical, the "expectant treatment" teacher. Faith in the curative power of medicine, sober judgment in recognizing its limitations, and, above all, enthusiasm in its study and development, are necessary. The aggressiveness of surgery must be met by a correspondingly aggressive attitude, and the domains of medicine are to be protected, not by vainglorious words and empty boastings, but by undeniable successes.

APROPOS OF VEGETABLE PARASITES.

LAST month, in speaking of tuberculosis and a possible vegetable origin of the disease, we referred to the discovery of a bacillus very similar to the bacillus of Koch, found growing upon a certain kind of grain in France. Here, in the same line of thought, we wish to draw attention to another remarkable observation. Dr. Bra, who claims to have discovered the cancer germ, found micro-organisms similar to the alleged

parasite of cancer in diseased wood. In his desire to determine what, if any, relation existed between these micro-organisms and human carcinoma, he was led to inoculate several trees with cancer cultures. He claims in this way to have originated a morbid process which in one instance resulted in the death of the tree. Of course such a startling statement requires corroboration at the hands of others, but the possibility of its correctness dare not be denied. Should it be found that parasites, supposed to be peculiar to animal life, are capable of producing their destructive effects in vegetable organisms, or *vice versa*, as in the case of tuberculosis, we will have gained a highly important point of view for the study of the life-history of the omnipresent germs, which are the subject of so much investigation. The essential importance of nutriment and environment in modifying their growth and influence will come to be more clearly recognized, with the result of simplifying the study of bacteriology, and furnishing a ready and cogent explanation of many circumstances which at present seem irreconcilable with a universal germ-theory of disease. Whether we will thereby be brought any nearer to a knowledge of the cure of disease is another story.

THE PENNSYLVANIA STATE SOCIETY.

THE Homœopathic Medical Society of the State of Pennsylvania will be held at the Hahnemann Medical College, Philadelphia, on Tuesday, Wednesday and Thursday, September 26, 27 and 28, 1899. A large and enthusiastic meeting is anticipated, the Chairmen of the various Sections reporting the promise of a large and varied number of papers on practical scientific subjects teeming with interest for both the practitioner and specialist.

The great National Export Exposition which opens on September 14th in Philadelphia will be an additional incentive for the members of the Society to bring along with them their families and friends. The Philadelphia physicians, anticipating this, have devoted considerable energy to formulating plans for

the comfort and entertainment of both members and visitors, and their care will be in keeping with Philadelphia's well-known hospitality.

The sudden but beautiful death of the aged veteran and loved treasurer of the Society is a grievous blow, and comes to each member as a personal loss. His genial and kindly nature drew all to him, and held them as friends forever afterwards. The passing of a night carried his gracious soul from earth to spirit-land, and never again will it be ours to receive the benefit of his wise counsel and unselfish sympathy and support. Another treasurer may carry the burden of the Society in the hour of trial as modestly and loyally as he, but none can rightfully expect to win and hold the affectionate regard and admiration which went out to him unbidden in spontaneous unanimity.

The President, Dr. B. F. Betts, has wisely appointed Dr. Cooper's assistant, Dr Ella D. Goff, of 41 N. Diamond Street, Allegheny City, Pa., as Treasurer *pro tem.*, and the members should extend to her the courtesy and encouragement of promptly mailing their present and back dues.

The wise member will at once arrange to attend this meeting and will spend the balance of the week at the most unique exhibition ever held in this country—the National Export Exposition.

SMALL-POX IN PENNSYLVANIA.

WE wish to especially call the attention of our readers to the official communication from the State Board of Health of the Commonwealth of Pennsylvania, on page 134 of this month's *News and Advertiser*, in reference to the persistent spread of small-pox throughout a large part of Western Pennsylvania. We are on the verge of a widespread and alarming epidemic owing to carelessness in diagnosis, inefficient sanitation, and silly vaccination antagonism; and, unless the physicians of the State awaken to the dire need of their most active co-operation and support in the effort of the State Board of Health to stamp out the disease before the oncome of cold weather, the entire State may be visited by this dreadful scourge.

GLEANINGS.

OBSERVATIONS ON THE USE OF ANTITOXIN IN THE TREATMENT OF DIPHTHERIA.—M. A. Albl, M.D., Cleveland, Ohio, says: Every suspicious case should receive an injection at once, rather than wait for a bacteriological examination. If the case is one of streptococcus infection, neither good nor harm will be done, and if it proves to be a case of Klebs-Löffler infection, the patient will probably be promptly cured. He does not consider the different rashes—such as urticaria, exanthema, those resembling the scarlatina and measles, and polymorphous rashes, œdema, pyrexia and diarrhœa—as contra-indicating the use of antitoxin. He bases his experience upon 69 cases, resulting in 62 recoveries and 7 deaths.

Of these 62 cases 2 of them received three injections of 1000 units each every six hours until the effect was obtained; 6 received two injections of 1000 units each every six hours until the desired effect was reached; 8 received 1500 units at the first injection, which sufficed; 6 received a single injection of 1000 units; 8 cases had complications in the form of rashes. I have not observed any other complication. In injecting the antitoxin all anti-septic precautions were taken.—*Cleveland Medical Gazette*, June, 1899.

W. D. Carter, M.D.

PUNCTURE AND BLOOD-LETTING IN NEPHRITIS AND URÆMIA.—Prof. Ewald thinks diuretics and revulsion through the intestinal tract are not of much service in these conditions, therefore mechanical measures are indicated, particularly in great degrees of dropsy. We have not been, in such cases, energetic enough in the past. Puncture of the pleura and peritonæum are done at too long intervals, at weeks apart. Spontaneous absorption is hindered on account of the pressure, the nutrition of the endothelium suffers, and the functions of the surrounding organs are disturbed. Therefore he would puncture at the slightest indication, even every third or fourth day, and he claims to have obtained excellent results then, and to have cured many a nephritis. For puncture of the skin he employs long needles of the same size as for thoracocentesis, which are pushed in parallel with the skin, one or more needles in each leg, thus withdrawing from one to five litres every day. In a chronic case of Bright's, from September 10th till December 3d, 1896, he drew off 22.5 litres of fluid. In another he evacuated by puncture of the peritoneal cavity, from October 6th, 1896, to March 13, 1897, 140 litres in 40 punctures; during December and January he punctured every third day, with the result that the patient fully recovered. The quantity of albumin in the ascitic fluid was 0.6–0.75 per cent. Uræmia is a poisoning by products which should be excreted by the kidneys. Therefore nothing is more natural than by blood-letting to decrease the arterial tension and reduce the quantity of toxins. He withdraws from 200 to 400 grammes. In 62½ per cent. he obtained either permanent or transitory results. He is far from holding that

venesection is indicated in all cases of uræmia, but only where the condition of the patient and his heart permit.—*Norsk Magazin for Lægevidenskaben*, No. 5, 1899.

Frank H. Pritchard, M.D.

FULMINANT GANGRENE.—Dr. Lindenthal, of Vienna, at the Twenty-eighth Congress of the German Surgical Association, read a paper on gangrene foudroyante, based on six cases, a relatively numerous material. This affection, so called by Pirogoff, was met with in youthful individuals who were suffering from complicated fractures, with more or less accompanying crushing injuries. Pirogoff regarded it as a primary, mephitic and traumatic gangrene, while the later surgeons look on it as an acute purulent œdema and as an especially malignant form of phlegmon. It usually complicates grave injuries of the soft parts of the extremities, often combined with fractures or open wounds which have come in contact with dirt or dust. The gravity of the injury itself is not a necessary association. A very short time after infection, generally within forty-eight hours, there is diffuse œdematous swelling of the extremity, discoloration of the skin, vesiculation of the epidermis, coldness, insensibility of crackling of the skin on rubbing the hand over it. There are also serious general symptoms, as paleness of the face, cold sweat, small pulse and confused sensorium. Even if the mind be undisturbed there is no pain. Often icterus rapidly supervenes, and with a complete sense of well-feeling, death quickly occurs. The anatomical findings correspond to the progressive necrosis and gas formation. The skin is lifted from its underlying parts like an air cushion; on incising, a turbid, sero-hæmorrhagic fluid exudes. The muscles are of a dark-brown color, disintegrated, disseminated, with bubbles of gas, dry and lacerable, or soft and semi-fluid. The veins are thrombotic, the marrow in the vicinity of the fracture dark brown, often fluid. In the internal organs there is cloudy swelling, parenchymatous degeneration and bleeding into serous surfaces. No splenic swelling. In five of the six cases he has detected an anærobic bacterium, in the sixth one the bacterium coli commune. It ferments intensely albuminous bodies. He could cultivate it from the human intestine and the earth. It is very virulent for guinea-pigs. In recent years fulminant gangrene has been described under the name "gaseous phlegmon," though E. Fraenkel separated it from this.

Clinically, it is one of the most malignant infectious diseases of wounds. By far the greater number perish, and only an early amputation will save. Incisions and extensive disinfection were of no service. Clinically, a diagnosis may be made (1) *from the formation of gas under the skin*, and (2) *the progressive necrosis*.—*Wiener Medizinische Presse*, No. 19, 1899.

Frank H. Pritchard, M.D.

THE SYMPTOMS, DIAGNOSIS AND TREATMENT OF EARLY HEREDITARY SYPHILIS.—Dr. L. Rabek bases his conclusions upon about 300 cases of hereditary syphilis which made its appearance during the first few years of life. The lesions were most frequently seated on the skin, in the form of plaques in 204 cases, as papules in 41 cases, and sometimes the two were combined. Pemphigus was noted five and cutaneous gummata nine times. The skin of a child with hereditary syphilis is pale, of a darkish tint, as though washed with black coffee; under the light it appears as if thickly varnished, particularly so on the soles of its feet.

The mucous membranes presented discrete or confluent plaques, gummata, flat condylomata of the buccal cavity, pharynx, and most frequently coryza and ozena. It was much rarer that lesions of the muscles or involvement of the epiphyses, with consequent pseudo-paralysis, was met with (3 cases); finally, affections of the viscera or nervous system were still rarer. The considerable swellings of the spleen and liver which are noted in these children are not always syphilitic.

Children with hereditary syphilis are of a cachectic appearance, with their weight and dimensions below the normal. More than two-thirds of his cases were under three months. Roseola and coryza constitute the most frequent manifestations of the disease. When the symptoms are distinct a diagnosis is easy; but, in doubtful cases, one should inquire as to: (1) the antecedent health of the parents, skin eruptions, sore throats, hair falling out, bone pains, nightly aggravation of this or that symptom; (2) the health of the other children preceding and following this one; (3) the tendency of the mother to abort, whether she has aborted or brought any dead or decrepit children into the world; (4) and the state of this child from its birth. (In older children the teeth should be carefully examined for: 1, the notched teeth of Hutchinson; 2, the ears looked into for perforated drumheads; 3, the bones examined for exostoses; 4, the eyes examined for keratitis interstitialis or its relics, leucomata. As to the family history, all syphilites are liars!)

In the majority of cases there will be a history of abortions, or of children born prematurely which died soon after.

In children born apparently healthy, the syphilitic signs may appear after the fourth to the sixth week; therefore, one should not be satisfied with a single examination. Most frequently there will be noted to supervene: (1) ozena; (2) pallidity of the mucous membranes; (3) the dirty brown color of the skin; (4) the cutaneous eruptions; (5) the lesions of the mucous membranes; (6) and rarely those of the viscera. The ozena is rebellious, the eruptions are followed by pigmentation, and the condylomata leave cicatrices. It sometimes happens that one meets with the disease from the first to the third years, most frequently then as flat condylomata or gummata.

Treatment consists in good feeding, nursing either at the mother's breast or that of a syphilitic nurse. Bottle feeding rarely succeeds. The specific remedy is mercury, either as inunction, sublimated baths, or as calomel, internally. The best results he has noted from the bichloride baths. Otherwise, general tonic treatment and local measures, as indicated.—*Przegląd Chirurgiczny*, Tom. iv., Zezsył ii., 1899. [Anyone who understands German I should advise to buy and to read three times through, in succession, Dr. Donner's *Späetformen Angeborener Syphilis*, Stuttgart, 1896. There he will find more, condensed, on the late forms of hereditary syphilis than anywhere, and arranged in an attractive and entertaining manner, interspersed with clinical cases, illustrating the features, and, moreover, by a scientific homœopath. One cannot know too much of these obscure forms of hereditary syphilis. They may meet any of us, even in our very next patient.]

Frank H. Pritchard, M.D.

APPENDICITIS MAXIMS.—M. O. Terry, M.D., Utica, N. Y., says:

1. Remember that constipation and irregularity of the bowels are the factors to be considered, and that diarrhoea is simply an effort on the part of nature to relieve impaction, congestion and inflammation.

2. That cathartic medicine in some form should be administered at once, but that half an ounce of castor oil and the same quantity of sweet oil is to be preferred, followed immediately by a glass of hot water, which dose is to be repeated in three hours unless a thorough evacuation has been induced.

3. That the condition of the bowels desired is a stool free from hard lumps and yellow in character.

4. That morphine or opiates in any form should *never* be given in any state of the difficulty, as they smother symptoms and arrest the peristalsis of the bowels—a condition found in impaction, which at times nature tries to relieve by diarrhœa.

5. That for *pain* speedy relief is obtained by repeated hot flaxseed poultices covered with hot sweet oil or applied to the abdomen before the poultice. Also that enemas of half a pint of sweet oil, followed by soap or soda water in large quantities, are useful.

6. That in sharp attacks the high or colon enema should be given, and at times the patients should be placed in the Trendelenburg position.

7. That glycerin and water, in the proportion of 1 to 4, is to be used at times to dissolve impaction.

8. That food in acute attacks should be omitted, and only water allowed, and that freely. Later, oatmeal gruel strained, milk peptonized, mutton or chicken broth, with strained rice gruel.

9. All of the above suggestions should be carried out as indicated, vigorously, systematically and perseveringly.

10. The remedies used throughout as indicated are : Aconite, veratrum vir., belladonna, bryonia, phenacetin, calomel and soda tablets, pulsatilla and arsenicum. Tinctures are given in doses graded to the inflammation and idiosyncrasy of the patient in hand.

11. The calomel is given for two purposes in conjunction with the soda : (a) For its cathartic effect when the castor oil cannot be taken. It will be necessary in these cases to give from two and a half grains, with three times the amount of soda, followed by a glass of hot water, to five and occasionally ten grains.

12. (b) For chronic recurrent appendicitis, with marked thickening and plastic exudate into the surrounding tissues.

13. If you ask when to operate, I advise following the indicated line of rational surgery. If the quick pulse and pain do not subside speedily, or show improvement within a few hours, it will be good surgery to operate—if the patients will allow you to do so. If they do not, continue the “oil treatment” *vigorously*.

14. The easily-diagnosed pus case requires speedy surgical attention.

15. That half an ounce of sweet oil followed by a glass of hot water, taken half an hour before meals, should be continued until pain or soreness ceases, which may be three months. As improvement ensues, take two doses a day, and finally one.—*New York Medical Times*, August, 1899.

W. D. Carter, M.D.

A MODIFICATION IN THE OPERATIVE METHOD FOR INVETERATE AND RELAPSED CASES OF TALIPES EQUINO-VARUS.—Jonas (Omaha), after going over the various operations now in use for the correction of this deformity, namely, that of Phelps, and the modification practiced by (1) Lane, who

covers the wound on the second day with a large skin-graft; (2) Kellock's use of a thick flap from the outer side of the foot, turned across the sole to fill the gap, and (3) Gardner, who inserts a decalcified bone-wedge between the astragalus and scaphoid to unfold the foot outward, offers still another method.

A triangular flap is made, the incision beginning slightly below the margin of the plantar fascia, on the inner side of the foot, at a point on a line directly below and anterior to the internal malleolus, extending forward and upward to a point on the first metatarsal bone near the metaphalangeal articulation. A second incision is started at a point over the astragalo-scaphoid articulation, extending forward and slightly downward, joining the first cut near the metatarso-phalangeal joint. The incisions are deep enough to include the subcutaneous tissue and fat. The flap is then dissected backward, exposing all the shortened soft structures. The plantar fascia is divided diagonally, the claim being made that, after correction, a gap is not left between the scarred ends, lessening the tendency to contraction of this structure when repair is complete.

The remaining soft tissues are then divided successively, as in the Phelps' operation, until the astragalo-scaphoid capsule is reached. Instead of opening this, another incision is made, on the outer side of the foot, over the head of the astragalus, and the neck of this bone divided through with a chisel. The forward part of the foot can now be pushed outward without separating the astragalo-scaphoid joint, which nearly always occurs in the typical Phelps' operation. In marked cases, if this is not enough, the head of the astragalus can be removed.

The equinus position is relieved by subcutaneous tenotomy of the tendo-Achilles, and the foot over-corrected. The triangular flap is now turned back, covering the gap except at its anterior point. No sutures are used, but the wound is covered with perforated silk protective. The wound over the head of the astragalus is closed with catgut. Over the usual antiseptic dressing the author applies a plaster-of-Paris cast, extending from the toes to and including the lower third of the thigh. This case is left undisturbed for five or six weeks. On its removal the wounds are healed.

This method has been employed in the last four years twenty-five times with perfectly satisfactory results. To prevent relapse, suitable retentive apparatus must be employed. The advantages claimed for this method are:

- (1). The flap, on account of its broad attachment, is not likely to slough.
- (2). The flap is thick, and it more completely fills up the large wound than any other that can be used.
- (3). The defect left underneath the flap fills with a blood-clot, the healing process being identical with the moist blood-clot as first used in bone-cavities by Schede.
- (4). There is no broad and deep granulating surface, causing, when epidermization is complete, abrupt and shelving sides.
- (5). No dead space is left between the ends of the severed fascia; its points still touch, and can be sutured if desired.

(6). The division of the neck of the astragalus obviates the necessity of opening the astragalo-scaphoid joint, and prevents the separation of these joint-surfaces, which always become recoaptated, contributing toward relapse.

—*Annals of Surgery.*

Gustave A. Van Lennep, M.D.

THE TREATMENT OF APPENDICITIS.—After three months' discussion by the Hospitals' Medical Society, the Society of Surgery and the Academy, it may be said that the communication received from M. Poirier, at the meeting of April 26th, reflects the general opinion. It lays down the following precepts :

1. There is no medical treatment of appendicitis.
2. In acute cases operate as soon as possible after the diagnosis is made.
3. In doubtful cases it is better to operate.
4. In subacute cases it is possible to wait and operate *à froid*, i.e., between the attacks, but most of the members prefer to operate at once.
5. Suppurative appendicular peritonitis demands instant operation.
6. In slight cases it is less risky to operate at once than to wait and operate *à froid*, and diagnosis, especially in the early stages, is anything but easy.
7. The steps of the operation must vary according to the needs of each particular case ; resection of the appendix should be practiced in every case where the search for it does not involve much injury to the tissues. The possibility of a ventral hernia (*éventration*) after the operation *à chaud*, i.e., in the acute stage, is not a reason for putting off operation, for the risk of this occurring is less than the risk from waiting.—*Phila. Med. Journal*, June 3, 1899.

F. Mortimer Lawrence, M.D.

STERILIZATION OF CATHETERS AND BOUGIES.—Nicol (Glasgow) gives the results of certain observations on the different methods now in vogue for the sterilization of catheters and bougies.

Metal bougies may, of course, be sterilized by heat, or by the same processes as are applicable to soft bougies.

Soft bougies, red, black, and yellow "gum elastic," will not stand heating by any method to a temperature sufficient for sterilization. Occasionally a bougie is encountered which will survive a single not too prolonged boiling or steaming ; repetition of the process is invariably destructive.

Soaking for fifteen minutes in carbolic 1 to 20, or for half an hour in carbolic 1 to 40, or for an hour in perchloride of mercury 1 to 1000, renders the surface of nearly all of them so sticky that the towel adheres in the process of drying, and the bougie becomes covered with fluff. If permitted to lie for an hour or two in the air this fluff dries, and may be readily wiped off. After several soakings the surface becomes dull and sticky and unfit for use.

A series of experiments undertaken to ascertain the value of Schimmelbusch's method of sterilization, washing with soap and warm water, rinsing in running water and drying with a sterilized towel or gauze, led to the following conclusions : The water used was the ordinary gravitation water of the town, the towels were from a reliable laundry. Thirty bougies of all makes and sizes, which had been previously used on infected cases, were subjected to the above method and cultures taken. Of these, seven tubes and plates showed growths, the majority being non-pathogenic moulds. It appears, therefore, that, with a certain amount of care, this method may be relied on to render the instruments sterile.

Red-"rubber" catheters are readily sterilized by boiling or steaming, and are not damaged by soaking for months in solutions of carbolic or bichloride of mercury. Gum-elastic catheters, red, black, and yellow, immersed in antiseptic solutions of efficient strength, are affected in the same way as bougies. This method of sterilization is, therefore, impracticable. Prolonged soaking

in carbolized oil is in no way harmful, but is unreliable, as the author proves conclusively by experimentation. Heat, of course, is destructive in the majority of cases, although it has been found that it is well tolerated by the "old red-varnished curved catheter."

Formol vapor in the hands of the author has also proved very unsatisfactory, the trouble seeming to be that the interior of the catheter, unless the lumen was large, was not acted upon by the vapor. The apparatus used was of the most approved form of French manufacture.

Steaming the interior of catheters for from ten to fifteen minutes by means of the various forms of kettles lately introduced for this purpose gave varying results. In general this method succeeded in sterilizing the *interior* of highly-septic catheters, but only under exceptional conditions did the process effect the sterilization of the *exterior* of a catheter. To overcome this difficulty, the author first fixes on the kettle a catheter of large lumen, and in it places the instrument to be sterilized, permitting the steam then to pass around it as well as through it. As to the effect on the catheters, it was found that the majority were softened and their surface rendered more or less dull. An exposure of twenty to forty minutes usually destroyed the instruments.

In drawing conclusions regarding his experiments, the author states that the soft, red-rubber catheter can be rendered perfectly sterile for an indefinite number of times either by boiling or by washing and immersion in sufficiently powerful antiseptic solutions without sustaining damage; but when it comes to all forms of "gum elastic" or "varnished" catheters, while there are various methods which are not destructive, and which offer a reasonable degree of security, *there is no method which is entirely reliable.*

For practice the following rules are suggested:

1. Avoid as far as possible the employment of catheters. In cases of stricture, metal or soft bougies which can be readily sterilized will be all that is necessary, with few exceptions.

2. When a catheter must be employed, use, where possible, a red-rubber Jacques' catheter. Washing with warm water and soap, rinsing in fresh water and douching in a 5 per cent. solution of carbonate of soda, followed by repeated washings in a 5 per cent. carbolic solution, or bichloride of mercury 1 to 1000, while not thoroughly reliable, offers a certain amount of security in the way of asepsis in preference to a gum-elastic or metal one.

3. In cases where a gum-elastic catheter must be used, if the urine is very septic it should be destroyed after use. If the urine be not very purulent or offensive, subject the catheters used to external washing with soap and water, and then with antiseptic solutions, followed by internal steaming. Those which survive may be kept.

4. For those cases where the regular use of a gum-elastic catheter is necessary, the patient is supplied with a catheter with well-finished interior. After use it must be thoroughly washed, held under the tap for a few minutes, and then put away in a dish of antiseptic solution. It is useless to expect an average patient to carry out anything more elaborate in the way of cleaning.

As a convenience in keeping and carrying catheters the author makes use of long, narrow tubes or bottles, fitted with rubber or metal stoppers, in which the instruments may be placed. Filled with antiseptic fluid they are at hand for the catheter after use, and when emptied of fluid may be used for storing the catheter while traveling.—*Annals of Surgery.*

Gustave A. Van Lennep, M.D.

THE USE OF PAROTID-GLAND EXTRACT IN THE TREATMENT OF OVARIAN DISEASE.—E. Pierre Mallett, M.D., New York, presents 20 cases treated with parotid-gland extract which showed marked improvement. The conditions varied from a simple acute salpingo-oöphoritis to conditions of varied chronicity presenting adhesions of the viscera, retroversions, anteflexions, retroflexions, prolapsus, etc. The extract was administered in three-grain doses three times daily. Ichthyol, combined with glycerin, on tampons, was applied to the vaginal vault, and ichthyol in capsules or pills, 5 grains, t. i. d., was also administered internally.

He says, in conclusion, "In briefly summarizing these cases I will not attempt any physiological explanation of the action of the parotid gland, but will simply state some of its effects as I have observed them.

1. "It has seemed to relieve the pains of dysmenorrhœa in all cases, without regard to alleged causes or present conditions, to a greater extent than any of the so-called uterine sedatives which I have been able to obtain.

2. "It relieves those dull, aching pains referred to the back and ovarian regions, usually designated by those familiar, though vague and unsatisfying, terms 'reflex pains,' 'neuroses,' 'ovarian neuralgia,' etc.

3. "Menstruation, when delayed, becomes more regular as to periodicity, and less in amount and shorter in duration.

4. "During its exhibition pelvic exudates seem to soften and become absorbed more rapidly under abdomino-pelvic massage.

5. "The general health, strength, appetite and spirits seem also to improve under its use, and those dull headaches, which constitute such an annoying and persistent symptom in these cases, is almost invariably relieved and in some disappear entirely.

6. "The only counter-indication that I have thus far met with in its use has been in cases of artificial climacteric, in which cases the flashes of heat and cold were distinctively made more frequent and severe."—*The American Gynec. and Obstet. Journal*, July, 1899.

W. D. Carter, M.D.

THE DIFFICULTY OF PRODUCING AN ABORTION IN CERTAIN CASES.—Turner Anderson, M.D., Louisville, Ky., reports a case of vesico-utero-vaginal fistula, with a laceration of the cervix, both of which were repaired. Sounds had been passed into the uterus several times during the operation, a drainage-tube had remained in the cervical opening for two days, and a sound had been passed subsequently upon recovery of the patient. The woman was two months pregnant at this time, and in spite of the manipulations she carried the child to full term. The physicians, of course, were unaware of her condition, her menstrual history being irregular.—*Obstetrics*, July, 1899.

W. D. Carter, M.D.

ACCIDENTAL INOCULATION OF THE EYEBALL WITH VACCINE VIRUS.—Dr. S. Potts Eagleton, in the July *Ophthalmic Record*, reports a case of accidental self-inoculation of the ocular conjunctiva by a doctor while engaged in vaccinating the arm of a patient. The capillary tube containing the virus was shattered accidentally, a portion of the contents of the tube being thrown with considerable force upon the right eyeball. Three days afterwards a large conjunctival bleb formed near the limbus of the cornea, with some constitutional disturbance, and, locally, lachrymation and itching.

The serum in the bleb was evacuated, and the eye treated with a solution of boric acid collyrium. An uninterrupted recovery followed.

The case is one of unusual interest, not only on account of its rarity, but from the fact that since the advent of the capillary tubes containing vaccine virus, and the almost universal adoption of the same by the medical profession, such accidents in the future may become more frequent in occurrence.

It is evident in this case that the general immunity of the patient's system prevented serious trouble. Had it been otherwise, and had a complete vaccination resulted from the inoculation, it is probable that a general panophthalmitis would have resulted, with loss of the eye.

Wm. Spencer, M.D.

EARACHE IN CHILDREN.—In many cases gentle inflation of the middle ear is more efficacious for earache than either heat or cocaine. Instead of the Politzer bag, the author prefers for this purpose two feet of rubber-tubing, provided with end-pieces of glass or other material—one for insertion into the patient's nostril and the other to be placed in the operator's mouth. The child is asked to puff out his cheeks, when the operator blows gently into the tube, and, the nostril being otherwise closed, the air enters both middle ears. Extreme gentleness should be used in this method.

As a prophylactic of earache, the child should be taught to blow the nose properly. The best method is by means of the Politzer bag, which is inserted in one nostril and the secretions blown from the other, this procedure being practiced two or three times daily. Local abnormalities should be corrected, and attention paid to the general health of the patient.—E. B. GLEASON, *Medical Council*.

FOREIGN BODIES IN THE PHARYNX AND ŒSOPHAGUS.—James R., in a paper (*Lancet*, May 6th), describes his experience with foreign bodies in the pharynx and œsophagus. Often a small body may set up alarming symptoms. He has removed fish-bones, orange-peel, pins, apple, match, date stones, plum-stones, camel's-hair brush, slate-pencils, set of false teeth, coins, etc. He advocates prompt, energetic treatment; first explore, after anæsthetizing locally the sulci between the fauces and the tonsil. Then examine with the laryngoscope. Examination with the head lowermost is favorable to coughing up the body, and there is not so much danger of dislodging the particle into the larynx or trachea. Extract by means of the double coin catcher or the sponge probang. Do not push rough, angular bodies into the stomach.

Perform laryngotomy or tracheotomy if there is great obstruction to the breathing. Œsophagotomy or gastrotomy is the last resort, the latter if the body is more than 30 centimetres from the teeth.

As practical rules, he gives: (1) Bodies which have remained some time and given rise to symptoms of obstruction, irritation or dyspnoea should be operated at once. (2) Forceful attempts at extraction per os are to be condemned. (3) Sharp, irregular, impacted bodies especially require œsophagotomy. (4) Sometimes gastrotomy and sometimes a combination of gastrotomy and œsophagotomy is required. (5) No stitches should be used where the wound in the œsophagus is ragged or its walls inflamed. (6) Otherwise stitch with continuous suture, not piercing mucous coat. (7) Only when no danger of infection or suppuration exists should the external wound be closed. (8) Liquid food may be given per os in twenty-four hours after the operation.

Wm. Spencer, M.D.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND
THERAPEUTICS.

THE THERAPEUTICS OF DYSMENORRŒA.—In the course of an interesting paper Neatby notes that the *Cyclopedia of Drug Pathogenesis* supplies us with only twelve drugs to meet this condition, viz., asarum, bromine, cactus, carbo animalis, actea, curare, cyclamen, lappa, phosphorus, sulphur, viburnum, xanthoxylum. He reviews his own use of nux vomica, pulsatilla, bryonia, lycopodium, hydrastis, ergot, sabina, and others, and concludes as follows:

1. Our pathogenetic material bearing on dysmenorrhœa is lamentably deficient, and urgently calls for fresh provings on women in a scientific manner.

2. A large proportion of our cures are made by prescribing "for the patient," i.e., on general constitutional indications.

3. There are two important drugs which correspond respectively with spasmodic and congestive dysmenorrhœa, viz., secale and sabina. These are best given between the periods, two or three times a day, and at the time every half hour or hour. The higher dilutions of secale seem to act better for the immediate relief of pain. The typical spasmodic case must be accurately selected for on the lines laid down to secure the success of the remedy.—*Journal of the Brit. Hom. Society*, July, 1899.

REMEDIES FOR SYMPTOMATIC PHASES OF PHTHISIS.—Wheeler mentions some drugs which, given intercurrently for troublesome night cough or night sweats, do not affect the physical signs but add much to the patient's comfort. Hyoscyamus is, perhaps, most often given for the cough, and does well, but he prefers conium. A drug that he often finds indicated is drosera, and it answers admirably when the cough is spasmodic. For sweating, ac. phos. or silicea; if sweating is bad enough to resist these, jaborandi nearly always acts splendidly. For hemoptysis he prefers ferr. acet. Millefol., too, he has used with success. In a case now under treatment, where there seems to be more tendency to the formation of fibrous tissue than actual cavity, he has had a good deal of improvement from graph. 1x trit., given because of its reputed relation to fibrous tissue.

F. Mortimer Lawrence, M.D.

THE INDIVIDUALITY OF REMEDIES.—Dr. Stambach, in order to aid in choosing remedies from their mental peculiarities, presents the following:

Aconitum.—Never produces any effect if the patient be not nervous, full of apprehension, anxious, agitated, affected and tormented by a fear of death.

Bryonia.—A quiet patient who is in bad humor and who drinks a great deal of water.

Belladonna.—The patient is very red, with a high temperature, sweats, his heart palpitates, and his tendons jerk.

Chamomilla.—The pain renders him restless and peevish, with a desire to toss about.

Anacardium.—The patient swears like a trooper.

Nux Vomica.—The patient is surfeited, bilious, irascible, a true club-man.

Sulphur.—The patient is uncombed, with towsy hair, of a dirty complexion, eczematous, and "a great enemy of baths."

Capsicum.—Lazy, fat, sweats easily, relaxed, awkward, sleeps but little and suffers from homesickness.

Abies Nigra.—It seems as though a hard-boiled egg had been swallowed entire.

Acid. Aceticum.—He feels sad on account of his disease and his children, hectic tendency, œdema, emaciation, diarrhœa, anasarca with thirst, croup with redness of the child's face.

Bromium.—Blond, blue eyes; in croup.

Cactus.—Taciturn, sorrowful; he thinks himself incurable and fears the future; "a sense of constriction."

Calcareæ Carbonica.—Blond, soft, flabby patients, who fear that they will lose their reason; sweating of the head, neck, and upper part of the chest; those who eat eggs greedily, and whose feet are cold and clammy.

Calcareæ Phosphorica.—The child cannot support its head; of a brownish complexion; headache of school children, with diarrhœa. It strengthens the bones and prevents rickets. Flabby and emaciated children who cannot stand nor learn to walk.

F. Mortimer Lawrence, M.D.

A FEW REMEDIES IN SENILE HYPERTROPHY OF THE PROSTATE.—Dr. Cooper speaks very highly of the value of ferrum picrate in the frequent desire to the first stage of senile hypertrophy of the prostate. These patients complain of frequent desire to urinate at night, with interrupted sleep as a consequence; no constipation, prolapse of the rectum, incomplete evacuation of urine; in fact, it gradually diminishes the quantity of residual urine. Another symptom is a scalding pain at the neck of the bladder, which is not the tenesmus of cystitis nor the pain of subacute or chronic attacks of prostatitis of adults, in which latter the remedy does not act. Here the picrate, alternated with *buchu* 1x, is very useful, in either the second or third dec. dil.

Calcareæ iodata is also recommended as a remedy for the same pathological state in the prostate. (Jousset advises the iodide of sodium or potash.) In another variety of hypertrophy the bladder is wholly emptied, there is no retention of urine, yet these patients complain of frequent desire to urinate, drawing pains in the perinæum and large intestine, and hæmorrhoids. Here the posterior portion of the gland is hypertrophied, and catheterization reveals but little residual urine. Ferrum picric will give good results. In great hypertrophy with dilation of the bladder, as well as those with fetid and alkaline urine, disinfectant irrigations of the bladder are first required, after which the picrate may be of service.—*L'Art Medical*, No. 4, 1899.

Frank H. Pritchard, M.D.

CORNUS CIRCINATA IN SKIN AFFECTIONS.—According to Douglas, this remedy is of unusual value in skin affections, its indications being: Itching of the scalp, legs and feet, increased by scratching and rubbing. There is always a fine, scarlet rash, attended by severe itching. The skin is generally covered by a copious, clammy perspiration.—*Clinique*, August 15, 1899.

GUAIACOL-VASOGEN IN TONSILLITIS.—Guaiacol-vasogen will, in many cases of tonsillitis where there is a tendency to quinsy, relieve the local inflammation promptly. It is best used in a 20 per cent. solution applied to the tonsils by a camel's-hair brush.—*Clinique*, August 15, 1899.

VASELIN FOR TUBERCULOSIS.—Weber, in a communication to the Berlin congress for the study of tuberculosis, advocates the subcutaneous injection of vaselin for the cure of tuberculosis, claiming that vaselin is a hydrocarbon which is oxidized in the blood with water and carbonic acid. He believes that the blood, when highly charged with carbonic acid, is inimical to the growth of the tubercle bacillus. He presented some statistics in substantiation of his claims.—*Clinique*, August 15, 1899.

F. Mortimer Lawrence, M.D.

ECHINACEA FOR BOILS.—Halbert, of Chicago, records the case of a woman, aged 40, who was supposedly of scrofulous diathesis, and who suffered every spring with boils, for which she usually took any "spring medicine" that her neighbors might prescribe. For some reason her last attack was apparently aggravated by her patent prescription, and she went through every sort of medical experience from cathartics to massage, and yet for two or three months the boils appeared, and increased in size and ugliness. For a month the writer worked at the case without result. Finally his attention was called to echinacea, which was given in 10-drop doses of the first decimal attenuation six times daily, with most satisfactory results.—*Clinique*, August 15, 1899.

ASPIDOSPERMINE IN ASTHMA.—Halbert reports the case of a mechanic who had been under treatment for a long time for a chronic emphysema, with acute asthmatic attacks. Opiates, chloroform, amyl nitrite, etc., had been resorted to as palliatives, the relief being transitory. He used the second decimal attenuation of aspidospermine every half-hour, or oftener, during attacks, and continued its use for a long time after. It not only aborted the acute attack, but greatly relieved the emphysematous tendency. An irritating laryngitis and dyspnoea, which were of frequent occurrence, were also helped.—*Clinique*, August 15, 1899.

F. Mortimer Lawrence, M.D.

MYRISTICA SEBIFERA FOR ULCERATIONS.—This drug is spoken highly of in conditions of ulcerative tendency in all tissues. It is claimed that it acts more powerfully than hepar sulphur or silicea. It resembles the action of iodium, calcarea and sulphur in scrofulous maladies. The part used is the juice obtained by puncturing the bark of the tree. It is indigenous to Brazil, and is of the same genus as the nutmeg.—*Clinique*, August 15, 1899.

ASCLEPIAS TUBEROSA IN PULMONARY DISEASES.—Asclepias is a remedy too frequently overlooked in pneumonia and bronchial troubles. It has been used by the eclectics in the form of a tea, not only for the dry cough in the early stages of pneumonia, but for the febrile state as well. It will reduce the fever in conditions similar to those calling for aconite, without, however, any cardiac depression. It is useful in the dry-cough period, when the lungs are first involved; there are sharp and cutting pains in the chest simulating the bryonia symptoms. We also find many rheumatic symptoms call for it; the pains are always in the larger joints, and are "shooting" in character. Myalgia of the intercostal muscles, with some pleuritic symptoms, are clinical features when it is indicated.—*Clinique*, August 15, 1899.

ANACARDIUM IN ACUTE DISEASES, WITH MENTAL PERVERSIONS.—Halbert reports in detail four cases which, with many others of similar character, have confirmed his belief that anacardium has a very beneficial action upon the mental brain. Its physiological action corresponds to a general cerebral depression following extreme excitement or acute febrile conditions; the mental action is always inco-ordinate; anxiety is one of its leading symptoms, and suspicion is always a prominent characteristic; anæmia and exhaustion are always present, and a sense of cerebral pressure is a common complaint.—*Clinique*, July 15, 1899.

F. Mortimer Lawrence, M.D.

REMEDIES FOR EPILEPSY.—Strontium is a remedy which has in the last few years been quite thoroughly used by the profession, and with varying degrees of success. The bromide has recently been lauded as a specific in epilepsy. Some recent comparative results by a physician who has investigated its use in a great many cases of the kind would lead to the conclusion that its bromide features, at least, are dangerous. It is still doubtful if any bromide may be used with tolerance. The best recent remedy for epilepsy is by all means *ver-bena hastata*.—H. V. H. in *Clinique*, July 15, 1899.

THE TREATMENT OF PLAGUE.—Ghosh epitomizes the therapeutics as follows:

For prostration and carbuncles—ars., carbo. veg., china, lachesis, merc., sil., a. nitric.

For nervous symptoms—bell., hyos., veratrum, stram.

For buboes—ars., carbo veg., china, merc.

For gastric complications—ipec., nux vom.

For diarrhœa—ars., veratrum.

For hæmorrhages—crotalus, lachesis, the tincture of *figus religiosa*.

The last-named medicine, *figus religiosa*, is the discovery of Dr. Ghosh, and is prepared from the fresh leaves of the tree. It may be used with almost magical benefit when bleeding from any organ appears, and when hæmorrhage and bloody evacuations trouble the patient.—*Hom. World*, June 1, 1899.

F. Mortimer Lawrence, M.D.

DYSPEPSIA OF UTERINE DISEASES.—Dr. F. Cartier claims that in sepiæ we have a remarkable remedy for the dyspepsia of uterine and utero-vaginal affections. The characteristic indications are: profuse and permanent leucorrhœa, which may be vaginal and whitish or uterine and watery, staining the linen greatly, which apparently is due to a hypersecretion of the uterine glands. In both varieties of leucorrhœa, the thick and yellow as well as the clear, thin and watery, *sepiæ* is indicated. This leucorrhœa, on account of its profuseness, brings about a characteristic dyspepsia, with drawing sensations in the stomach and a sort of heaviness of the organ as though it would fall from its normal position. The vision is weak and the least exertion causes headache. These three symptoms are characteristic of sepiæ.

Helonias dioica is a great analogue of sepiæ in leucorrhœa and presents very pronounced backache of uterine origin, with heaviness in the thighs and a "sensation of a uterus." *Helonias* is useful to stimulate the appetite in women with uterine affections. He advises it in the first dec. dil., and sepiæ in the sixth to the thirtieth dec. trituration.

F. Mortimer Lawrence, M.D.

THE HAHNEMANNIAN MONTHLY.

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THE RELATIONS OF HOMŒOPATHY TO ALLIED SYSTEMS OF THERAPEUTICS.

BY JAMES C. WOOD, A.M., M.D., CLEVELAND, OHIO.

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(Special Address delivered before the Amer. Ins. of Hom., Atlantic City, N. J., June 21, 1899.)

THE treatment in vogue for inflammatory fever when Hahnemann became a student of medicine was* “venesection until the pulse returns to its proper strength.” For cerebral and meningeal inflammation, “bleeding from the jugular vein and temporal artery, repeated as often as the strength admits.” For ophthalmia, “bleeding, especially from the jugular vein; cupping on the nape of the neck; leeches to the temples and below the eyes, frequently repeated; purgatives and antiphlogistic medicines; blisters applied to the neck, behind the ears, on the head and temples; setons and issues in obstinate cases.” For pneumonia, “large and repeated blood-letting; when the strength does not admit of further venesection, cupping should be performed betwixt the shoulders; clysters, blisters, large doses of tartar emetic, etc.” For toothache, “venesection, mercurial purgatives, sudorifics, emetics, scarifying the gums, leeches to gums, blisters behind the ears, etc.”

Is it any wonder that even as early as 1790 Hahnemann wrote, regarding the then existing method of treating disease,

* Homes' *Principia Medicinæ*.

"Bleeding, antiphlogistics, tepid baths, diluent drinks, low diet, blood purifiers and everlasting purgatives and enemata are the vicious circle in which the ordinary run of physicians are always revolving"?

It was a long way from venesection to aconite; but to the Sage of Meissen we are indebted for the abandonment of a practice which killed more people than all the wars of the old world. It was a long way from Alexander's Golden Antidote, containing seventy-seven ingredients, to the single remedy; but the "Porcelain Painter's Son" traversed it with one stride, inaugurating a practice the advantages of which are acknowledged in one of the latest old-school works on Therapeutics in the following words: "The scientific physician usually prefers to administer remedies separately, in order to more accurately observe their effects, as well as to discontinue, or change the dose of, any one which may be necessary."* It was a long way from the cruelties which characterized the treatment of the insane one hundred years ago to the present non-restraint system; but it was he who was driven from town to town by jealous apothecaries, who first wrote, ". . . the treatment of madness should be conducted with a view to the absolute avoidance of corporal punishment." It was a long way from salivating doses of blue mass to fractional doses of mercury; from blisters, setons, issues, caustics and cauteries to soothing dry and moist heat; from powerful purgatives to pleasant laxatives: but the German lad whose father early gave him lessons in "thinking" inaugurated a new system of practice, and so directed his shafts of sarcasm at the horrible and disgusting methods then extant, that no modern physician of any school would dare to revive them. Men like Fletcher, Mott, Forbes, Liston, Trousseau and Bristowe, of the older school, have had the moral courage publicly to acknowledge the genius of Hahnemann, and the good he wrought in the way of therapeutic and hygienic reform.

I have indulged this much in retrospection for the purpose of contrasting the past with the present. More than one hundred years have now elapsed since Hahnemann enunciated the law of cure which is the foundation-stone of this, the Ameri-

* White's *Materia Medica and Therapeutics*, 1898.

can Institute of Homœopathy. Marked changes have during this period taken place in the dominant school of medicine—in the pharmacology and therapeutics of that school as well as in its attitude toward the homœopathic. Time has proved that Hahnemann was right in rejecting the pathology of his day, but I surmise that if he were now living his attitude toward the existing school of pathology would be very different from what it was in 1796. Indeed, Hahnemann's habit of inductive reasoning led him to anticipate many modern pathological theories. He early recognized that there is some latent cause which perpetuates chronic diseases, and that cause he traced to psora, syphilis and sycosis. Autenrieth has practically indorsed the psoric theory, and the French pathologists now recognize the *diathèse herpétique*. Lawson Tait affirms that gonorrhœa is responsible for more disease and suffering than syphilis; and while he doubtless had in mind, in making this statement, the local manifestations of the disease as it attacks women, a gonorrhœal dyscrasia (sycosis) is now recognized by all clinicians. Physiologists have again introduced into their nomenclature the terms "vital force" and "vital resistance," and all clinicians admit that there is a "something" constantly met with in contending with disease which makes one patient susceptible to, and another proof against, infection and contagion. The constitutional element is now admitted by physicians of all schools; and while it would be claiming too much for the founder of homœopathy to say that his early theory of chronic diseases is entirely responsible for the present theories of causation, we can at least safely maintain that Hahnemann did more than any single individual did before his time, or has done since, to emphasize the importance of correcting constitutional dyscrasiæ by constitutional measures.

The germ theory of disease was anticipated by Hahnemann. As early as 1831 he alleged "that cholera was propagated by organisms which were conveyed by the air," and he advised the administration of camphor in material doses "in order to destroy these pestiferous microbes." Doubtless, were he alive to-day, he would be one of the most ardent of asepticians, as, while living, he was one of the most ardent of sanitarians. He would recognize that asepsis and antisepsis, as related to the germ theory of disease, have to do with the prevention rather

than the cure of morbid processes, and he would have no fear of this theory invalidating in the least the law of similars.

While the modern scientist demands a minute demonstration of methods, it is unfortunately true, as Albutt says, that experimental methods can be satisfactorily applied only to the exact sciences. In the biological sciences it is impossible to repeat experiments as in chemistry and physics. This is especially true of medicine, for in disease no two cases are alike, and it is impossible to make invariable deductions because of constitutional bias, race temperament and environment. It is true, nevertheless, that bacteriology enables us to isolate conditions in many instances, though "the number of variables is at all times embarrassing." If this be true in this last year of the nineteenth century is it strange that Hahnemann attributed disease to an "unseen spirit" because he could not determine its cause? Again to quote from Albutt, "Even in this day physicians have not assimilated the lesson that disease is not an entity but a particular state of the body, and has no more of a separate or objective existence than, let us say, the constellations of the Great Bear or Charles's Wain."*

The chief feature which distinguishes the homœopathic school from the allopathic is that the former deals with the manifestations of disease rather than with its essence. The so-called regular physician, if his conceptions of scientific medicine are carried to logical conclusions, must have an intelligent theory of disease, with sufficient knowledge of the remedy to conform with the disease theory. The history of medicine shows the uncertainty of the premises upon which this high ideal is based. Galen, Paracelsus, Stahl, Boerhaave, Von Helmont and Cullen all tried to create systems of medicine founded upon the hypotheses set forth, and history records the results. During the last one hundred years pathological theories have come and gone like the morning dews, and the hypothetical qualities ascribed to medicines have, with few exceptions, proved uncertain and useless when subjected to ultimate clinical tests. I grant that by slow and laborious process pathological data are now at our command which are invaluable to the clinician; but, comparatively speaking, pathology is yet in its develop-

* *Johns Hopkins Hospital Bulletin*, December, 1898.

mental stage so far as causation is concerned. The shibboleth of the orthodox school is yet *tolle causam*, but the theory of causation adopted by one decade is discarded by the next; hence confusion reigns supreme, and vaunted specifics appear and disappear with kaleidoscopic rapidity. The germ theory of disease is the possible exception which proves the rule, and since it promises something tangible in the study of causative factors, it would seem as though it had come to stay. However, up to the present time this theory, while it has enabled us to accomplish wonders along the line of preventive medicine, has done little or nothing towards the development of pharmacodynamics.

I cannot better contrast the advantages of attacking the phenomena of disease rather than its essence than by citing two remarkable and somewhat recent illustrations. When Dr. Koch gave to the world his tubercular lymph he had builded a theory based upon hypotheses which conformed to the requirements of orthodox conditions. Tuberculosis was supposed to be caused, and doubtless is caused, by living organisms called bacilli. The lymph produced by Koch was supposed to possess qualities which fitted it to the theory of the disease. While those qualities were necessarily hypothetical, the chain of logic seemed unbroken, and marvellous cures were prophesied and promised. Berlin suddenly became the Mecca of physicians and invalids from all over the world. But I need not weary you with the details. The Koch-cure has now become a matter of history. Time has proved that the lymph is beneficial in certain types of tubercular disease, as it has also proved that it is beneficial in those types because it is homœopathic to the symptoms which characterize them. Had Koch recognized the necessary corollary of the law of similars, the minimum dose, he would have been spared the aggravations and disasters which followed his treatment; had he been more familiar with the workings of that law, he would early have known the types of cases in which his "tuberculin"—a term long familiar to our school—was applicable. Koch's treatment of tuberculosis has become unpopular because it was based upon theory, and theory is ever shifting and variable.

Let me now cite an illustration of a different character. At the Detroit meeting of the American Institute of Homœopathy

Prof. T. F. Allen presented a clinical case, the cure of which was accomplished by another method. The patient had been to various noted specialists and had received various diagnoses. There was some lesion of the nervous system, which gave rise to the phenomena of "progressive muscular atrophy," and there was a pretty general consensus of opinion among the old-school fraternity that the disease was incurable and probably fatal. Dr. Allen ignored, so far as treatment was concerned, all the learned opinions which had been put forth relative to the pathology and prognosis of the disease in hand. A fatal termination would, of course, confirm the prognostic theory, and only a fatal termination could confirm or disprove the several pathological theories—annihilation being necessary, in either case, to leave undisturbed the succession of events which comply with all requirements of "scientific" medicine. But Doctor Allen's business was to contend with the manifestations of the disease, not its essence. As an intelligent physician, he was of course quite as familiar with the possible histogenic and gross tissue changes as were his old-school *confrères*; but this knowledge, had it been absolute, would have availed him but little in curing his patient. The totality of symptoms suggested phosphorus, and phosphorus wrought a cure, not because the disease was or was not progressive muscular atrophy, but because its subjective and objective manifestations had their counterpart in the provings of phosphorus upon the healthy. His prescription was based upon a law of nature immutable and unchangeable: Koch's was based upon a hypothesis put forth to explain known facts and phenomena. Doctor Allen would be quite as unscientific as was Dr. Koch were he to advocate phosphorus as a remedy applicable to all cases of muscular atrophy, even had he known with absolute certainty that the changes in the central nervous system were those giving rise to this affection.

The bit of inductive reasoning done by Hahnemann regarding cholera and its treatment is too familiar to justify anything more than reference to it. It is along the same line, and I am not sure but that it is the only instance the history of medicine affords where the correct treatment of disease was outlined by one who had never seen a case, and who knew little or nothing of its causation or pathology; the treatment was based

upon the phenomena of cholera, and not its essence. It did for medicine, so far at least as the homœopathic school is concerned, what Newton, and Kepler, and Ohm did regarding our knowledge of the physical universe—proving that the treatment of disease, like all other physical phenomena, is under the dominion of law.

If, then, we are right in the assumption that the law of similars is a law of nature, and that it is the most universally applicable law of cure yet enunciated, as well as the most beneficent, let us ask ourselves the following questions:

1. Why has it not been more generally recognized by the dominant school of medicine as a working law in therapeutics?

2. What are the limitations of this law in the treatment of disease, and what should be our attitude toward other methods and systems of cure?

These are vital questions to homœopathy, and upon their correct solution much depends. We must meet them fearlessly and without equivocation. We are at the threshold of a new century, and one hundred years has created a new school of thinkers in all departments of science. We must take new bearings, and deal with modern conditions by modern methods. By so doing we shall win for homœopathy many bright men who are kept from the school because of certain features which characterize it; features which are driving some of our best minds from us. In undertaking to answer these questions I shall act in the spirit of one who believes with his whole soul in the beneficence of the law of similars; so much so that his most ardent wish is to see it recognized as the guiding law in all schools of medicine. That I shall answer the questions satisfactorily to all, or even to the majority of my hearers, I do not expect.

1. "Why has not the law of similars been more generally recognized by the dominant school of medicine as a working law in therapeutics?"

I shall first note the fact that all great innovations destined to promote the welfare and happiness of mankind have been bitterly assailed by men acting under the influence of human passions and human prejudices. It was preached from the pulpit regarding vaccination "that Providence never intended that the vaccine disease should affect the human race, else why

had it not before this time visited the inhabitants of the globe." Said the learned divines, "The law of God prohibits the practice; the law of man and the law of nature loudly exclaim against it."

When anæsthesia was introduced, M. Magendie, the distinguished physiologist, argued before the French Academy of Sciences that "pain has always its usefulness;" he doubted if there was a true advantage "in suppressing pain or rendering the patient insensible during an operation," and argued that "it was a trivial matter to suffer (*c'est peu de chose de souffrir*), and a discovery whose object was to prevent pain was of slight (*mediocre*) interest only."

Nearly fifty years after Harvey had announced his great discovery to the world, the Paris Royal Society of Medicine gravely listened to an essay which classed it among the impossibilities. Galvani was facetiously dubbed "the frogs' dancing-master." Lavoisier, the noted French scientist, declared, in discussing the possibility of aerolites, "there are no stones in the sky, and therefore none can fall upon the earth." Benjamin Franklin was greeted with shouts of laughter by the Royal College of Physicians of Great Britain when he declared the identity of lightning with other electrical phenomena. As recently as 1822, Daguerre came very near being assigned to an asylum for affirming that he could fix his own shadow on magical metallic plates.* And certain men are still opposing antisepsis and asepsis, even though thousands of lives are annually saved by the practice inaugurated by Lister.

While, then, the same dogmatism of science which has characterized all centuries and epochs will account for much of the opposition with which homœopathy has had to contend, there are other factors inherent in homœopathy itself which cannot be ignored. Chief among these, in my opinion, is the fact that certain men of the homœopathic school have insisted, and still insist, that the *Organon* as an exponent of homœopathy must be accepted by the followers of Hahnemann, literally and in its entirety. The words which I used at the beginning of this paper, indicate with sufficient clearness my admiration of the genius of the Master. I shall

* *Epochs in Medicine* (Wood).

not be charged with disloyalty, then, if I say that certain passages of the *Organon* have done more to retard the growth of homœopathy than all other things combined. I, of course, allude to the theory of dynamization, to the method of administering highly potentized drugs by olfaction, and to the theory that a single dose of a highly potentized drug continues to act almost indefinitely for days, and even for months.

So far as the theory of dynamization is concerned, I am not even going to argue for or against it. I recognize the fact that, historically, it is a part of homœopathy, and that men like Dunham, Boenninghausen, Hering and Raue testified in no uncertain words to the efficacy of the higher potencies, as do many men now living who are earnest, honest and successful. I recognize the fact, too, that (in the words of Dr. Hughes) "infinitesimals of a most minute character are assuming an undoubted place and reality in the world of being." I would not restrict a single individual member of this Institute in his belief regarding the value of the higher dilutions; to do so would be to throttle freedom of thought and to stifle progress. But criticism of the *Organon* should not be confronted by "traditional views," which, as Dr. Briggs puts it in discussing higher biblical criticism, "do not wish to be disturbed, and by dogmatic statements which decline investigation and revision." With the exceptions noted, the *Organon*, judged even by the searchlight of later nineteenth-century methods, is a work of transcendent genius, and contains much which is almost prophetic. Nevertheless, we should take it for what it is worth, and should not hesitate ruthlessly to reject that which experience, reason and science declare absurd. We cannot expect to win converts by presenting to them unthinkable theories; we cannot expect to retain within our ranks bright and liberally educated men and women, if we permit those theories to remain an integral part of homœopathy.

The great conquests of homœopathy have been won by the lower potencies, and it is hard for one of a materialistic turn of mind, like myself, to understand the necessity of departing from the realm of matter into that of spirit in dealing with the question of dose, especially inasmuch as most of the high-potency advocates contend "that the size of the dose, so long

as it does not produce aggravations, is immaterial.”* I repeat that I do not pretend to know to what extent matter and molecules are divisible. This ground has been repeatedly threshed over in the past, and so far as I can see but little good has come from it. My regret is that extreme infinitesimalism, and that which belongs to it, has become so intimately associated with homœopathy as to keep it from becoming what it should be, the dominant system of therapeutics. A student educated in the modern school of thought will not be circumscribed; he demands reasonable hypotheses and debatable premises. Furthermore, he demands liberty of action, and unless these are furnished him by homœopathy he will seek elsewhere. The proving of drugs upon the healthy is generally recognized by the older school; and the law of similars is admitted by nearly all as at least applicable in individual instances. The theory of dynamization as enunciated by Hahnemann is, however, beyond their grasp, and so long as we cling to it as a working hypothesis, just so long shall we fail to gain that recognition in the world of science to which we are entitled. For humanity’s sake let us take the stand which will bring to the largest number the blessings of homœopathy.

2. “What are the limitations of the law of similars, and what should be our attitude toward other methods and systems of cure?”

I shall not take up seriatim the so-called antipathic, allopathic and isopathic methods of cure and discuss them in detail. Together with homœopathy they are to be included under the head of pathogenic therapeutics, for in all of the four methods an effort is made to create one disease or lesion in order to supplant another. In the antipathic method the relationship between the existing disease and that to be created is one of direct antagonism; in the allopathic it is one of indefinite diversity; in the isopathic it is one of sameness or identity; and in the homœopathic, one not of identity, but of similarity.

The exceptions to the antipathic method are so numerous

* Hahnemann’s dosage as traced by Hughes shows that until the later years of his life he used and advocated the lower potencies.

that we are warranted in setting it aside as a working law in therapeutics. It is safe to say that while palliation is possible by this method, cures rarely result from it. Thus it is obvious that an antipathic relationship exists between constipation and diarrhœa; but it is hard to imagine an opposite "to scarlatina, measles, pneumonia, whooping-cough or dysentery, and a host of other familiar yet dreaded affections." (Dake.)

The allopathic method is the very climax of empiricism. The aim is to make morbid impressions by the drug or drugs administered, in this way instituting an artificial disease in the same organ and tissues affected, or in other organs and tissues, in order to supplant the natural disease. As a working hypothesis in accomplishing cures it has proved to be of even less value than the antipathic method.

The isopathic method is doubtless useful in certain cases, but to apply it intelligently it is absolutely necessary to know the *cause* of the disease—and we have seen how difficult it is to determine, even in the majority of instances, the factors responsible for given affections.

This leaves us, then, nothing but the law of similars to stand upon, except, indeed, remedies which act mechanically or chemically. But to what extent is this law applicable in the treatment of disease? Our own Dake, of precious memory, has so concisely expressed my own views upon this subject that I quote from him in full. He says,* in discussing the sphere of similia: "If the relationship is the same in all cases where drugs act curatively, the principle thereby revealed must be universal, and, therefore, the paramount law of cure." But he further says:

1. "The homœopathic law relates to no agents intended to affect the organism chemically.
2. "It relates to none applied for mechanical effect simply.
3. "It relates to none required for the development or support of the organism when in health; and
4. "It relates to none employed directly, to remove or destroy parasites which infest or prey upon the human body."

To this series of propositions I would add:

1. It relates to none which act in a purely eliminative way to rid the system of poisons and ptomaines.

* *Therapeutic Methods.*

2. It relates to none which act in a purely physiological way, as a food; and

3. It relates to none which act in a purely stimulative or palliative way.

The first proposition set forth by Dake implies an infallible *materia medica* and an infallible mind to select the drug.

That we have not an infallible *materia medica* is evidenced by the various conferences which have been held in connection with this Institute to improve it; that we are infallible beings would not be claimed even by one possessing the "conceit of omniscience." We must, therefore, utilize whatever good there is in empiricism—and it were passing strange if three thousand years of empiricism had not taught us much. We must continue to eliminate toxins and ptomaines by cathartics and sudorifics. We must stimulate the heart in cases of imminent danger by antipathic and physiological measures. We must dissolve gummatous tumors of the brain by chemical doses of the iodide of potash. We must feed our chlorotic and anæmic patients with physiological doses of iron, if they need them. We are to utilize local measures if local measures are necessary, and we may have to assuage suffering by pain-destroying agents. In short, we must be physicians first and homœopathists secondly—ever ready to utilize that which experience has demonstrated best for our patients. Whatever there may be good in suggestion (and suggestion will explain at least 50 per cent. of the cures made by all methods) in serum therapy, in mechanics, in chemistry, or in preventive medicine, belongs to us quite as much as to our old-school *confrères*. Homœopathy has a broad field of application over and above all these expedients and methods; it excludes nothing outside of its domain which is useful. But empirical methods and expedients can be made unnecessary in the larger number of cases by the intelligent application of the homœopathic remedy, and this point cannot be too emphatically insisted upon. We must, therefore, keep it before the world until the law of similars is recognized by every physician, every medical college and every medical society in the land. Until such recognition is obtained we are forced to remain a "sect" with a distinct name.

IS THE BREAK IN THE RADIUS THE ONLY BONE LESION IN COLLES' FRACTURE?

BY GUSTAVE A. VAN LENNEP, M.D., PHILADELPHIA, PA.

(Read before the American Institute of Homœopathy, Atlantic City, June, 1899.)

THERE is, perhaps, no other single fracture of so much interest or of such frequency as fracture of the radius near the wrist. Next to the ribs, we find the lower end of the radius the most frequently broken bone of the skeleton. In 432 cases of fractures of all kinds treated in the Emergency Ward of the Hahnemann Hospital of Philadelphia during the past year (May 1, 1898, to May 1, 1899), there were 50 cases of Colles', a percentage of a little over 10.

It is, moreover, of particular interest to surgeons and general practitioners alike, affecting as it does the function and symmetry of one of the most useful members possessed by man. What can there be more unsightly than a bunched-up wrist and a hand displaced to the radial side? Add to this a serious interference with the movements of the hand and fingers, and you have a perfect picture of the unfortunate results too often obtained after a Colles' fracture.

There is no doubt that in certain cases more or less deformity is inevitable, due to comminution of the fragment, loss of structure through impaction, and excessive callus formation with all its attending ills; yet how often one sees cases where there are unmistakable signs of poor reduction, or a failure to recognize an impaction which has gone unremedied until too late.

It is of some interest to know that this fracture was not recognized as such, but invariably mistaken for a backward dislocation of the wrist, which was considered the only lesion, till about one hundred years ago, when Pouteau first pointed out its correct nature and gave a good description of it. This opinion, however, was not shared by his successors, and the injury was still overlooked until 1814, when Colles published his accurate account of the fracture, which led English sur-

geons to apply his name to it. It only remained for Dupuytren, in 1820, to again bring it before the attention of the profession, and shortly after this the fact was universally accepted.

The advent of the Roentgen rays has given a fresh impetus to the study of the pathology of this fracture, as of all other bone lesions. It has also been of incalculable service in enabling the surgeon to satisfactorily clear up many a doubtful case, show the amount of displacement present, the existence of associated bone lesions, and finally demonstrate whether reduction has been successfully carried out.

Colles stated in his article that the fracture occurred from one inch to one inch and a half from the articular rim. This has subsequently been proven to be incorrect, the fracture usually occurring much farther down, from one-third to three-quarters of an inch above the articular border, at a point where the bone, although broadened out, is structurally weakened on account of the compact substance being thinned out and replaced to a certain extent by cancellous bone.

Six radiographs of recent fractures showed the following measurements :

In one the fracture was $\frac{3}{4}$ of an inch from the articular rim.

In two the line was $\frac{3}{8}$ of an inch above.

In one, $\frac{5}{8}$ of an inch.

In one, $\frac{1}{2}$ of an inch.

In one, 1 inch.

These measurements were taken from about the centre of the bone, at a point on the articular rim where it begins to curve down to form the prominent styloid process.

The line of fracture may be transverse, which is usually the case, or at times is oblique, antero-posteriorly, or laterally, the internal border being broken higher up than the external or ulnar side. In the young it sometimes follows the epiphyseal line, although this seems to be unusual. The possibility of such an injury must be borne in mind, and the patient cautioned concerning subsequent arrest of growth of the bone. Stimson (*Fractures and Dislocations*, p. 281) cites two such cases occurring at 12 and 15 years of age respectively, and gives radiographs. The subject is exhaustively treated by Poland (*Trau-*

matic Separation of the Epiphyses). The lower fragment is, moreover, very apt to be comminuted with crushing, or, if this does not take place, there is, in the majority of cases, more or less impaction. The fragment is rarely completely displaced backward, but appears to be tilted backward and outward, and its cancellous structure penetrated to a varying degree by the compact layer of the posterior surface of the radius—the radial styloid process follows the fragment, rising to a higher level, and changes its relation to that of the ulna, which remains stationary, thus giving us one of our most valuable diagnostic signs. The radial side of the bone is shortened, carrying the carpus upward, and allowing the hand to drop to the inner side, at the same time making the head of the ulna unduly prominent. This subluxation is increased by the giving way of the radio-ulnar ligaments and the spreading apart of the two bones.

Associated with this, the principal fracture, are found a number of lesions, the majority of which have been demonstrated by the aid of the Roentgen rays. There may be fracture of the lower end of the ulna, or fracture of the styloid process of the ulna. The first is rare; the second is probably the most frequent complication with which we have to deal. Stimson (*Fractures and Dislocations*, p. 275) seems to doubt the prevalence of this lesion, stating that the Roentgen rays have proven it to be less frequent than formerly supposed. In opposition to this view we have the researches of Kahleyss (*Med. News*, March 5, 1898, p. 306, from *Deut. Zeitschrift für Chirurgie*, vol. xiv., p. 531), who radiographed 48 cases of recent fracture with the following interesting results: Fissures of the radius were found twice, both cases produced by a fall on the back of the hand. The whole thickness of the bone was involved in 99 per cent. of the cases. The styloid process of the radius or a part of the articular surface was broken in 11 per cent. Comminution of the fragment was found in one-third of all the cases, and in three-fourths of these the lines of fracture were Y-shaped. Contrary to previous teaching, he found the fracture to be a trifle higher, from one-half to one inch from the articular brim. The displacement was invariably upward, backward and outward. Fracture of the styloid process of the ulna was found in 78 per cent. of all the cases, making this by far the most common complication.

Judging from this report, it would appear that fracture of the ulnar styloid occurs much more frequently than has been previously supposed. Probably the majority of these cases were overlooked until the Roentgen rays revealed their frequency. Without the aid of the rays it seems doubtful to the writer if the fracture can be recognized; certainly not with any degree of certainty, although at times, if the process is entirely detached, and there is not much swelling, it may be possible to grasp the loose piece between the thumb and index finger and obtain abnormal mobility. Even this, however, is extremely difficult to recognize by the most experienced. We must, therefore, call to our assistance the Roentgen rays, and it is not sufficient to make a casual examination with the fluoroscope. It is better in all cases to obtain a radiograph, as it is by the latter method alone that we are able to clearly see and study the lesions present.

Brown (*Annals of Surgery*, Philadelphia, 1898, xxviii., p. 657) reports the case of a woman who sustained a Colles' fracture in the ordinary way. Radiography showed a chipping-off of the styloid process of the ulna, but only after three skiagraphs had been taken, each at intervals of about two weeks. This apparent failure of the X-rays to disclose lesions in bone has been noted in a number of instances. In one case, where there were present all the symptoms and signs of a fracture of a metacarpal bone near its base, even to deformity, radiography failed to show the break, although the outlines of the bones were perfect. It was only after several attempts, with the hand in various positions, that the lesion was satisfactorily depicted.

In the radiograph presented to the Institute is seen a comminuted fracture of the lower end of the radius. The fragment is very badly broken up and impacted, the radial side of the bone suffers more than the outer or ulnar side, and there is also a small square piece of bone detached from the inner side of the diaphysis. In addition, there is seen also a fracture of the styloid process of the ulna, with the displacement of the small fragment in such a way as to indicate that it had been wrenched off the bone through the action of the external lateral ligament, which is attached to it. This is probably the usual mechanism of production. When the radius breaks, and the fracturing force continues to act, the hand is forcibly turned

inwards and upwards, thus putting the cord-like external ligament on the stretch, and, as is very apt to occur when it comes to a test of strength between ligament and bone, the latter gives way.

The fracture occurred in a large, muscular man—the result of taking a “header” from his wheel while coasting down a hill. There were the usual symptoms of a Colles', masked, to a certain extent, by swelling—the case not being seen till twenty-four hours after the accident. The break in the radius was readily recognized, but the fracture of the ulnar styloid was not found, or even suspected, till after the skiagraph had revealed it. The result in this case, considering the amount of comminution and crushing, was good; function is almost perfect, though at times the wrist feels weak and gives way. There is considerable bunching of the lower end of the radius, with displacement of the hand to the radial side, prominence of the head of the ulna, and perhaps a little thickening of the latter.

Eddington (*Glasgow Med. Journal*, 1898, i., p. 118) reports a case of comminuted fracture of the base of the radius, with separation of the styloid process of the ulna.

It would appear, judging from the lesions in these two cases, that fracture of the styloid process of the ulna should be looked for when the violence has been excessive, producing comminution, and has been received in such a way as to force the carpus inward to an undue degree, thus putting the external lateral ligament on the stretch, or impacting the triangular cartilage against the ulna. It would also be reasonable to suppose that, in the presence or absence of fracture of the ulnar styloid, there must be more or less damage done to the external lateral ligament or displacement of the triangular cartilage.

There occurs invariably, in addition, rupture of the radio-ulnar ligament, the evil effects of which show themselves late. One case treated in the Hahnemann Hospital Dispensary, with apparent excellent result, came back, some weeks after the splints had been removed, with an ugly prominence of the end of the ulna and a widening of the wrist, which, the patient stated, had gradually come on with the return of function. This is a good point to bear in mind in the management of this fracture. It is our custom to always prescribe a wristlet of some sort, or at times a leather strap to be worn above the

joint after the splints have been cast aside, in order to allow the slow process of fibrous-tissue repair time enough to be properly carried out.

As to the cause of Colles' fracture, the history usually shows it to be a fall on the outstretched hand. In the elderly it is usually a fall to the ground while walking; in younger persons, a fall from a height. The blow is invariably received on the palm about the region of the thenar or hypothenar eminence while the hand is extended. Rarely the opposite is the case, *i.e.*, a fall, striking on the back of the flexed hand. This form of violence is apt to produce fracture, with forward displacement of the fragment; rare, but possible.

Roberts (*Fractures of the Radius*) has collected a number of instances of recorded cases where the displacement of the fragment was forward—invariably the result of a fall on the back of the hand—and likewise shows by an experiment on the cadaver (page 45) that forcible flexion of the hand, after forcible extension which has broken the bone, can produce a forward displacement of the lower fragment. This is of considerable interest and well to bear in mind, although it hardly seems possible that it has ever occurred in the living. As Roberts says in another place (page 1), the displacement is the direct "result of the vulverating force," and is not influenced in any way by muscular action.

Destot and Gallois (*Rev. de Chir.*, 1898, No. 10), in a series of experiments, place the hand on the ground in various relations to the forearm, and apply a blow on the olecranon. The following deductions were arrived at:

1. The ligament that plays the most important part in the production of the fracture is the radio-ulnar. The interosseous or lateral ligaments are entirely passive when the hand is fully extended and with no lateral deviation.

2. The fracture is produced by the impaction of the radius against the carpal bones, and the transmission of force to it through the radio-ulnar ligaments.

3. When the hand is abducted the fragment is carried backward and outward (this is the usual displacement), and there may be a fracture of the scaphoid, with or without the lesion of the radius.

4. In adduction there often occurs a fracture of the inner portion of the radius only.

It will thus be seen that the displacement of the fragment and the variety of fracture produced depend to a great extent on the direction of the vulnerating force, and the latter, in turn, is influenced by the position of the hand at the time of injury.

The other theory advanced by some—that the bone is broken through the traction of the anterior ligament, or what is known as the “cross-strain” mechanism of production—seems to have met with considerable opposition. The force is supposed to be received on the palm below the ball of the thumb, forcing the hand in a position of extreme extension, making the anterior ligament of the wrist tense, and causing a fracture by avulsion.

Stimson (*Fractures and Dislocations*, p. 278) shows that the blow is usually received on the ball of the thumb; the anterior ligament, therefore, is not put on the stretch and cannot produce the fracture, and that the hand, in an ordinary fracture, is not bent back even to a right angle. Khaleyss thinks that the fracture is the result of cross-strain and blow combined. The most plausible cause seems to be that of Destot and Gallois—impaction of the radius against the carpus and crushing of the lower end between it and the diaphysis. This theory also explains the comminution so frequently found.

The diagnosis depends on the variety present. In complete fracture with displacement, the lesion can be recognized at a glance; the “silver-fork deformity,” the displacement of the hand to the radial side, the widening of the wrist and the prominence of the ulna are signs which can hardly be mistaken for anything else. In those cases, however, where impaction has taken place with no displacement the problem is harder. Here, perhaps, the most valuable sign is the change of relation undergone by the styloid processes of the radius and ulna; that of the radius is found to be on the same level as, or even a little higher than, that of the ulna, instead of being about a quarter of an inch lower, which is normal. If the lower end of the radius is palpated, it may be possible to appreciate a certain amount of thickening or bunching. The hand will be displaced to the inside and the head of the ulna prominent. If a well-defined transverse line of tenderness on pressure can be found on the dorsum of the radius, together with the history of the accident and loss of power, then a diagnosis of fracture should be made and the case treated as such.

Unlike other fractures, abnormal mobility and crepitus are very often lacking or difficult to obtain. A diagnosis, however, can be made without the aid of these two signs. In complete fracture with the usual silver-fork deformity, mobility and crepitus are unnecessary, the only other lesion which could resemble it being a backward dislocation of the wrist. This, in the first place, is rare, and a differential diagnosis can be made by locating the styloid processes and comparing their relation to each other and to the carpus.

Distinction between sprain and impacted Colles' is much more difficult, in some cases almost impossible. The swelling of sprain is more compressible and in the region of the joint and carpus, also more noticeable on the back of the hand; the pain, on pressure, is over the joint, while in fracture with little displacement the swelling would be firmer, being due to altered osseous relations. Pain is present on pressure along a ridge on the dorsum of the bone, about half an inch from the radio-carpal joint, deepening of the transverse grooves on the palmar surface of the wrist, and thickening of the lower end of the radius, as compared to its fellow. It sometimes happens that a positive diagnosis cannot be made one way or the other. If radiography, then, is not available, I believe it to be the duty of the attending physician to etherize all such cases and make an attempt at reduction. If there has been a fracture, crepitus will be obtained when the impaction is broken up, and the bone can then be moulded in position. If only a sprain is present, no harm has been done, and the attendant has the satisfaction of knowing positively what condition he is treating.

Two interesting cases come to mind. A gentleman fell, getting off a street-car, and was referred to us for the treatment of a sprain. The symptoms were obscure, but an impacted fracture was suspected. Examination with the X-rays showed an irregular blurred line extending across the lower end of the radius. Ether was administered. Manipulation broke up the impaction, the fragment was easily moved, and the bone moulded into good position. The result was good.

In another case a patient presented himself at the Hahnemann Hospital Dispensary a week after the receipt of an injury to the right wrist, asking if something could be done for "this sprain." A tendency to thickening of the base of the radius,

with tenderness and slight deviation of the hand to the radial side, led us to administer an anæsthetic, when, on forcible manipulation, an impacted fracture was broken up and the bone moulded into position.

Do not be afraid of using too much force in attempting a reduction of this kind. Roberts (p. 73) recommends bending



Comminuted Colles' Fracture with Chipping off of Styloid Process of the Ulna.

the forearm at its lower end across the knee. By this method he has succeeded in effecting reduction in two cases of old unreduced Colles', one of four months' and the other of six months' duration (page 76).

The experience of others has not been so fortunate. The writer records two failures to refracture—one in an old woman,

who had a typical "silver-fork" deformity of three months' standing, and the other a Colles' of three weeks' standing, which had gone untreated, in a child of 3 years of age. The latter may have been an epiphyseal separation. There was perfect use of the hand—no pain and no swelling. In the former, on the contrary, pain was constant and excessive, some swelling and heat, and marked interference in the movements of the fingers and wrist. This bears out Roberts' statement that "Fracture at the base of the radius must be reduced if deformity, protracted convalescence, prolonged rigidity of joints and pain are to be avoided." (*Annals of Surg.*, 1899, xxiv., 272-279.)

Failure to properly reduce, in my mind, is due to the fact that the fragments are not separated from each other enough to disentangle them. To accomplish this purpose, I believe that traction and counter-traction in the line of the deformity, supplemented by hyper-extension of the hand, should be most vigorously carried out; and that, when not otherwise contraindicated, ether should be administered to overcome muscular spasm and allow of more thorough manipulation. For this purpose the stage of primary anæsthesia is all that is necessary.

In the after-treatment, the question of a proper splint is an important one. For ordinary use, the Levis perforated tin is the best. It preserves the normal curve found at the lower end of the forearm, keeps the hand turned to the ulnar side, and leaves the fingers free—three essential points. If not obtainable, a plaster-of-Paris removable splint makes a good substitute (W. B. Van Lennep, "A Few Thoughts Concerning Fractures," *HAHNEMANNIAN MONTHLY*, February, 1897). The bandage should be snug, not tight, and the fingers moved to prevent adhesions of the tendons. Among other dressings may be mentioned that of Carr, Bond's splint, the adhesive dressing of Roberts, and Barnes' modification (*Med. Rec.*, N. Y., 1899, lv., p. 87). If a straight splint is used, it should be put on the dorsum of the wrist and forearm—never on the palmar surface.

In conclusion, the following points are brought out for emphasis:

1. Fracture of the lower end of the radius is often comminuted and impacted, frequently complicated by fracture of

the styloid process of the ulna, laceration of the radio-ulnar and lateral ligaments, and subluxation of the head of the ulna.

2. The secret of success in treatment is thorough reduction of the displacement.

3. Every impaction must be broken up forcibly and the fragment thoroughly reduced.

4. Every suspicious case of "sprain of the wrist" should be etherized, and an attempt made to break it up. If successful, there has been an impaction; if unsuccessful, there is a sprain. An intact lower end cannot be broken by manual force.

5. Whatever splint is used, the fingers must be left free and constantly moved. Dressings should not be left on too long.

6. A wristlet should be worn after the removal of the splint, to prevent spreading apart of the radius and ulna.

7. Passive motion, massage and electricity are necessary to restore function.

REFLEX DISTURBANCES CAUSED BY EYE-STRAIN.

BY E. H. LINNELL, M.D., NORWICH, CONN.

(Read before the American Institute of Homœopathy, Atlantic City, N. J., June 21, 1899.)

MANY functional nervous diseases are recognized to-day as reflex neuroses, that is as caused by an irritation existing in some remote organ and transmitted through nerve-channels, which are sometimes devious and intricate, to the part where the symptoms are manifested.

The tendency of specialism is to produce narrowness of view and to bias the judgment. The claims of over-zealous enthusiasts in one department or another who would have us believe that all nervous affections, and even organic lesions, are caused by irritation in some organ or tissue to which their attention has been exclusively devoted, have resulted in many useless, and even harmful operations, and have led others to underestimate the influence of such reflex irritations. A careful investigation and weighing of evidence notwithstanding brings the conviction that many cases are thus induced, and

teaches the progressive and careful physician to consider all possible sources of reflex disturbance in the elucidation and treatment of obscure nervous affections. *Tolle causam* is a maxim of prime importance, and nothing is more unscientific than for the homœopathic physician to content himself with the mere matching of pathogenetic and clinical symptoms, ignoring the modern means of exact diagnosis.

The object of this paper is to direct attention to the eye as a frequent and often unrecognized source of nervous strain, resulting in varied forms of functional nervous disorders. I shall illustrate and emphasize my arguments by cases coming under my own observation.

Headache is perhaps the most frequent form of neurosis resulting from eye-strain. A very large proportion of chronic headaches are due to this cause, and often the individual is unconscious of any visual defect or difficulty of using the eyes. This is so well understood and recognized that any extended remarks are unnecessary. A single striking instance may, however, not be without interest.

Miss M. J. B., a school teacher, about 30 years old, had suffered since childhood with very frequent and severe headaches, coming on at irregular intervals, especially after any excitement. The pain usually commenced in the right temple, and extended in all directions over the head. She described it as a steady, constant ache, aggravated by light and noise, but not worse at any special time of the day. When unusually severe, the headache was attended by nausea. Her general condition seemed excellent. Careful examination showed the heart and kidneys to be entirely healthy. Appetite and digestion were good, and all functions seemed to be regular and normal. Before consulting me, she had for a long time given up any treatment for her headaches as altogether useless, and relied upon antikamnia or similar palliatives during an attack. After all other probable causes for her suffering had been eliminated, she very reluctantly submitted to an examination of her eyes, declaring that she never had any inconvenience from using them, and that she was convinced that they were all right, and that there was no possible connection between the eyes and the headaches.

Vision of each eye was $\frac{15}{13}$, and the lines on the dial were all

seen with equal distinctness, but both the ophthalmoscope and the ophthalmometer indicated the existence of astigmatism.

Under paralysis of accommodation by scopolomine V.O.D.= $\frac{1.5}{100}$; with $+1.75D^s = +.50D^c$ $90^\circ V = \frac{1.5}{15}$ and the lines were again uniformly distinct. V.O.S.= $\frac{1.5}{100}$; with $+1.75D^s = +.75D^c$ $90^\circ V = \frac{1.5}{15}$, and lines distinct. Previous to using scopolomine there was an esophoria of 4° in distant vision, and an exophoria in accommodation of 3° .

After recovery from the influence of the drug, she accepted only $+ .75D^s$ with each eye in addition to the cylindrical lenses, and there was then an esophoria of 3° in distant and an exophoria of 2° in near vision. While the effects of the scopolomine were passing off, that is while the accommodation was imperfect, she suffered severely with headache. Sphero-cylindrical lenses according to the last examination were prescribed for constant use. These did not correct the whole error of refraction, but she could not at once voluntarily relinquish the tension of the ciliary muscle to which she had all her life been accustomed, and therefore vision with the stronger lenses was indistinct.

No relief of the headaches followed the use of these glasses, and prisms for the relief of the lack of muscular equilibrium were combined with them, and again we were disappointed. She very reluctantly persisted in wearing the first glasses for four months, during which time remedies were prescribed with some benefit. At the end of this time she accepted the lenses which corrected the whole error of refraction, as disclosed under the influence of the cycloplegic, and the headache vanished permanently as soon as she commenced to wear them. All medicine was at once discontinued; and as an evidence that the glasses cured her, and not the medicine, I wish to state that on one occasion, when she was obliged to go without them for a couple of days, the old headache immediately returned with great severity. To use her own language, "I thought I should have died, and am now thoroughly persuaded that you were right, and that my eyes were the cause of my headaches."

This patient had a splendid physique, and endured the long nervous strain remarkably well. Other persons of a less vigorous constitution or of a neurotic temperament would have

undoubtedly developed neurasthenia in some form. It needs no argument to convince any physician of the depressing effect of severe and long-continued pain; and if the influence of eye-strain is admitted as a factor in the causation of chronic headache, I think it will also be readily admitted that it may be an indirect cause of general nervous exhaustion, with its attendant and varied symptoms, such as insomnia, neuralgia, indigestion, malnutrition, and disturbed function of various organs.

Did time permit, numerous cases might be cited in illustration, but I have more important and convincing testimony to offer as to the injurious effects of eye-strain. Those who have followed me thus far will smile with incredulity when I assert that even insanity may be thus produced, but I offer the following bit of personal experience in support of my assertion.

Mr. J., about 36 years old, and a lawyer by profession, had for several years in succession suffered recurrent attacks of mania. These attacks came on during the latter part of summer, and lasted several months. They were characterized by intense physical restlessness, insomnia, irrational talk and profanity, to which he was not addicted in health, a disposition to make extravagant gifts to indifferent persons, unusual and foolish behavior, moroseness, suspicion and destructiveness. On one occasion he chopped a hole in the floor of the parlor, and on another he commenced to knock down the supporting pillars of the house in the cellar. During one or two attacks previous to his coming under my observation he had been treated by Dr. N. Emmons Paine, of West Newton, Mass., whose diagnosis was recurrent mania, and whose prognosis was repeated attacks for years.

He was first brought to me for examination and treatment in September, 1897, during the initial stage of his annual attack. I endeavored to make a thorough and exhaustive examination of his condition, both mental and physical, in the hope of discovering some hitherto unsuspected cause for his malady. The result was that I detected a slight nephritis, a moderate fullness of the retinal veins, as shown by the ophthalmoscope, and a hyperopic astigmatism, with a slight hyperesophoria. The examination of his eyes was very difficult and unsatisfactory, owing to his mental condition. Of course, the

use of any drug to paralyze the accommodation, which would have been most desirable, was absolutely contraindicated, and his own statements of visual acuity were not altogether reliable.

After several trials the following glasses were prescribed for constant use, viz.:

+ .75D^c 90° with prism 1° up O.D.
+ .75D^c 90° O.S.

His diet was restricted to non-nitrogenous articles as far as possible, and I gave him remedies under the advice of Dr. Paine for about two weeks. At the end of that time it was deemed unsafe to keep him longer at home, and he was taken to Dr. Paine's sanitarium. The latter wrote me: "It seems to me your examination of his eyes and fitting him to glasses will be helpful; and whether it will prevent a recurrence of the maniacal condition next year is a question I should like to see solved by time."

He improved rapidly, and came home in the latter part of November. He had not then perfectly recovered, but seemed to be entirely well soon afterwards. He continued under my observation, and recovered completely from the nephritis, as was shown by repeated chemical and microscopical examinations. In March, 1898, he had scarlet fever, and during the following August he had a very severe and protracted malarial fever, with a temperature which at times reached 105°, but he has never had the slightest return of mental alienation. In spite of his serious illness, last year was the only year since his first attack during which there has been no recurrence. His family tell me he has continued perfectly well and more natural than for many years.

It seems reasonable to attribute his recovery to wearing the glasses, because he has taken no medicine for the mental condition since returning from Dr. Paine. I have several times examined his eyes since, but have made no change in my original prescription. It does not seem probable that the nephritis was an important factor in causing the maniacal attacks, for it was never severe, and it was not of long standing, the casts being few in number and of the hyaline variety. The mental affection evidently antedated the nephritis.

It is unquestionable that epilepsy is often a reflex neurosis; and while I am not one of those who believe that it is always due to eye-strain, yet in the case which I am about to report it undoubtedly was thus caused, and the relief which followed the correction of muscular and refractive errors was so striking that it seems deserving of record.

It was that of a young man about 22 years old, who first consulted me two and a half years ago. For five or six years previously he had had epileptic seizures of increasing severity and frequency, which commenced while he was going to school. At first there was simple vertigo, but later genuine epileptic convulsions developed, with unconsciousness, and followed by deep sleep. These attacks recurred frequently, sometimes several times in twenty-four hours. He was treated by an old-school physician for some time, and later by a homœopathist, but derived no benefit from either. He became so nervous and apprehensive that he never left home under any circumstances. On one occasion he was persuaded to take a ride, but before going a rod he became so nauseated and generally used up that he was obliged to return. He is an intelligent fellow, and told me he had always thought there was a connection between his eyes and his "nervous attacks," as he called them. He expressed himself as follows: "When through over-excitement I experience one of the nervous spells, instantly objects assume a hazy aspect, and remain in that condition until my nerves are quieted. Again, if through reading or writing I overtax my eyes, my nerves are immediately affected, and remain so for a day or two, until my eyes are thoroughly rested." He could only read a few minutes at a time without vertigo and distress in his head, which lasted for hours.

The examination of his eyes was necessarily conducted at his home, and without a cycloplegic, to which he strongly objected.

The result was as follows: V.O.U. = $\frac{1}{15}$; with +.12D^s \subset +.50D^c 90° O.D. and +.25D^s \subset +.50D^c 90° O.S.V. = $\frac{1}{10}$ each eye, and radiating lines were uniformly distinct. Careful examination by various tests failed to detect the slightest hyperphoria. There was an exophoria of $\frac{1}{2}$ ° for distance and of 6° in accommodation. Owing to extreme nervousness and easy fatigue, the strength of the individual muscles was not tested.

Sphero-cylinders as above were prescribed for constant use, and the result was most satisfactory. I saw him six months later, when he was a changed man. His expression was bright and animated, his eyes were clear and bright, and he was able to use them freely without inconvenience of any sort. He had entirely recovered from his nervousness and apprehension, went about freely and fearlessly, and had engaged in business. He has had no convulsions since commencing to wear the glasses, now two and a half years ago. Once in about three months he has, always during the night, a very slight, scarcely appreciable tremor, but no loss of consciousness and no deep sleep.

Perhaps an examination now might reveal some uncorrected refractive error which would remove this faint suggestion of his former attacks, but he experiences no inconvenience from them, goes to business daily, and is to all appearances a perfectly well man.

Since the improvement was immediate and permanent, and since he has taken no medicine or received any other treatment, I think it is fair to conclude that the epilepsy was caused by eye-strain and was cured by correcting the ametropia. It seems also evident that the exophoria was not an important factor in the case, and was probably dependent upon the error of refraction, and not upon any abnormality in the muscles themselves or their attachments.

The obvious and logical conclusion from the study of such cases as those narrated is, not that all cases of epilepsy or all cases of functional nervous disorders are caused by ocular affections, but that many nervous troubles are of reflex origin, and that even such serious maladies as epilepsy and insanity may be sometimes cured by removing a source of irritation existing in some remote organ. If this is admitted, as I think it will be by most thinkers, then it becomes the obvious duty of the physician to investigate every source of possible reflex influence by the aid of all the modern means of diagnosis in the elucidation of an obscure case.

That eye-strain very often plays an important rôle in such cases does not seem strange when we remember how complex is the faculty of vision and how varied and intricate are the nervous activities which it involves. The first requisite for

binocular single vision is that an image of an object shall be formed upon corresponding portions of each retina. Otherwise the two retinal impressions cannot be blended into a harmonious single perception, and diplopia results. In order that the image may fall upon corresponding retinal points, it is essential that the functional integrity of the four recti and the two oblique muscles, by which the harmonious associated movements of the two eyes are secured, shall be unimpaired. This means uninterrupted and harmonious innervation along the lines of the third, fourth and sixth nerves, proceeding from physiologically intact centres, which preside over and regulate the ocular movements. The normal exercise of the faculty of accommodation is also essential to perfect vision, as well as the unrestrained movements of the iris, thus calling into exercise other fibres of the third and the sympathetic nerves. Supposing these factors to be physiologically and anatomically perfect, and the dioptric media to be transparent and of proper refractive power, the conduction of visual impressions along the optic nerve must be unimpaired, and the visual centres must be in healthy condition, in order that the impressions thus received may be converted into intelligent perceptions of form, size and color, and that accurate conceptions of the nature, distance and position of objects, may be obtained.

When we remember that during all our waking hours the eyes are in constant use for either distant or near vision, and when we consider the close application required of the student, the professional man, the bookkeeper and the skilled mechanic, we are in a position to realize the amount of nervous energy which is thus called for, and to appreciate the strain resulting from any abnormality of structure or function in the visual apparatus, and the influence which such a severe and constant strain exerts in the development and maintenance of functional neuroses. Undoubtedly this predisposing cause resides in a neurotic temperament, inherited or acquired. When such a temperament does not exist, such generally recognized exciting causes as dental irritation, helminthiasis, sexual irritation and strong mental impressions, such as fright, excitement or sudden grief, will not be sufficient to precipitate an attack; and the same is true of errors of refraction and muscular inequalities.

From the foregoing remarks, supported by the cases narrated

(many more might be cited, did time permit), the assertion seems warrantable that eye-strain should be included among the exciting causes in persons of a neurotic temperament, and therefore a careful and thorough examination of the eyes should never be neglected in any chronic or obscure nervous disorder.

Since preparing the foregoing paper, the case of mania reported has suffered a relapse. Shortly before he began to manifest symptoms of a renewed attack he came to my office for an examination of his eyes. I found he could not see quite as clearly as formerly with his glasses. Inasmuch, however, as he seemed perfectly well at the time, and used his eyes without inconvenience of any sort, I made no change in them. As soon as his condition permits, I propose to make a thorough examination of his refraction with the aid of a cycloplegic, and I expect to find some uncorrected error as an indirect cause of the present attack.

A COMPLICATED CASE OF FIBROMATA UTERI.

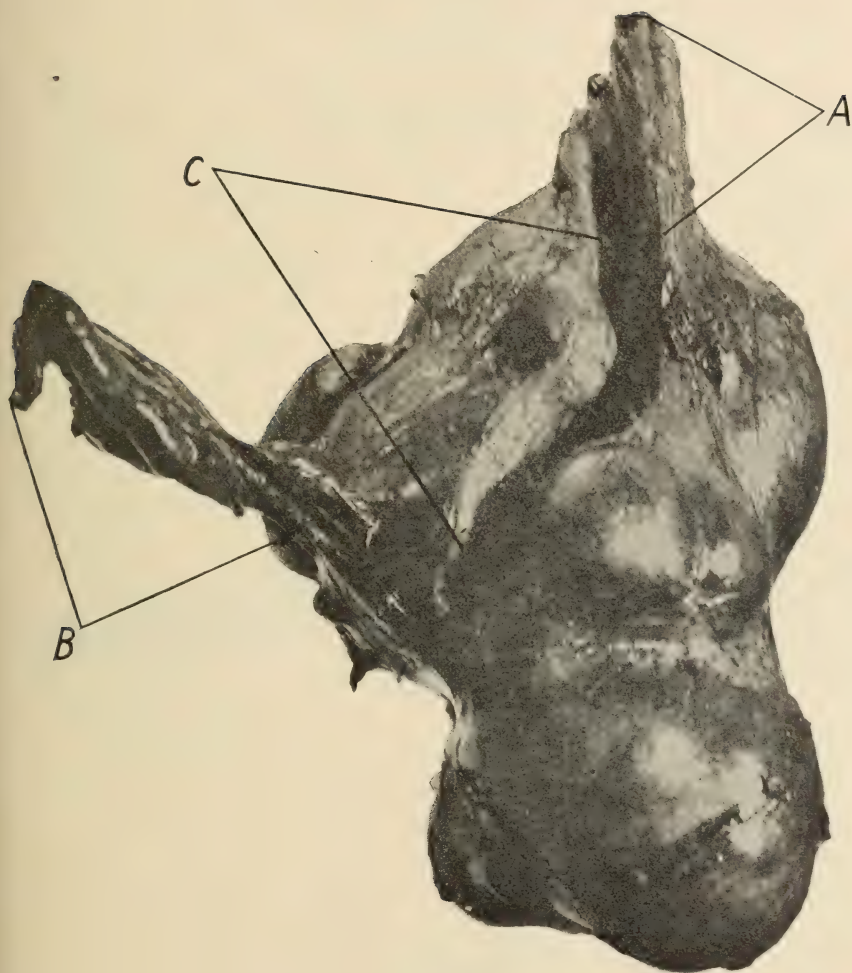
BY NATHANIEL W. EMERSON, M.D., BOSTON, MASS.

(Read before the Massachusetts Surgical and Gynæcological Society, June 14, 1899.)

ON June 27, 1895, I was called to see and operate upon Mrs. —, who was supposed to have a pus sac formed somewhere in connection with the pelvic cavity. The temperature was between 103 and 104 degrees, pulse about 120, with pain in the lower abdomen on the left side, and marked distention and tenderness in the same region. There was known to be a multiple fibroid of the uterus, and the present condition was a complication of the previous few days only. There was no marked bulging into the vault of the vagina, and, as her condition was one of great seriousness, it was determined to open the abdominal cavity. An incision was made in the median line, but, when the peritonæum was reached, a fluctuating tumor was found so intimately adherent to the abdominal wall that no line of demarcation could readily be discovered. The fluctuating mass extended to the line of the incision, filling the whole abdomen half way to the level of the umbilicus. As there was such marked bulging to the left, and the adhesions

were entirely inflammatory in character, I was misled, and thought I had to deal with an abscess cavity of an unusual nature. Thinking, therefore, that all I could do would be to open and drain it, I made a second incision above the left anterior superior spine of the ilium. Upon opening into the abdomen through this, the true nature of the condition was demonstrated to be an ovarian cyst. Through the second incision the inflammatory adhesions were not so dense, and so I was able to separate them from the cyst wall proper. This route was then abandoned, and return was made to the first opening in the median line. Through this the adhesions were separated with much difficulty, from the tumor upward lessening in density until the upper half of the tumor was spread bare; the lower half, however, was more and more firmly adherent the deeper I went, and the cyst wall itself was thicker and thicker as I proceeded downward. The tumor was finally enucleated so far as was possible, being attached below by a broad ligament as thick throughout its whole extent as the palm of the hand. All the lower parts of the tumor, as well as the broad ligament, were in an acutely inflamed condition, and the hæmorrhage from all parts was most profuse in character and most difficult to control; also, all the parts were fixed and non-pliable; and even when enucleation was carried as far as possible, by reason of the condition of the broad ligament the tumor could not be lifted out of the abdominal cavity, and it was with extreme difficulty that the broad ligament was tied off. The tumor, when opened, proved to be an ovarian cyst, which was in a state of acute inflammation, the inflammation having started somewhere in the vicinity of the broad ligament and proceeded upward. The upper portion of the contents of the cyst was clear, the middle portion turbid, and the lower portion pus, there being no distinct line of demarcation between the different strata, but a gradual blending of one into the other. In the course of enucleation a fibroid of the uterus was discovered, consisting of an indeterminate number of separate growths; but by the time the cyst was enucleated so that it could be removed, the patient's condition forbade further manipulation; also, the conditions were not favorable to an operation of such a character as had already been attempted, largely owing to improper instruments and accessories and in-

To face page 640, October, 1899.

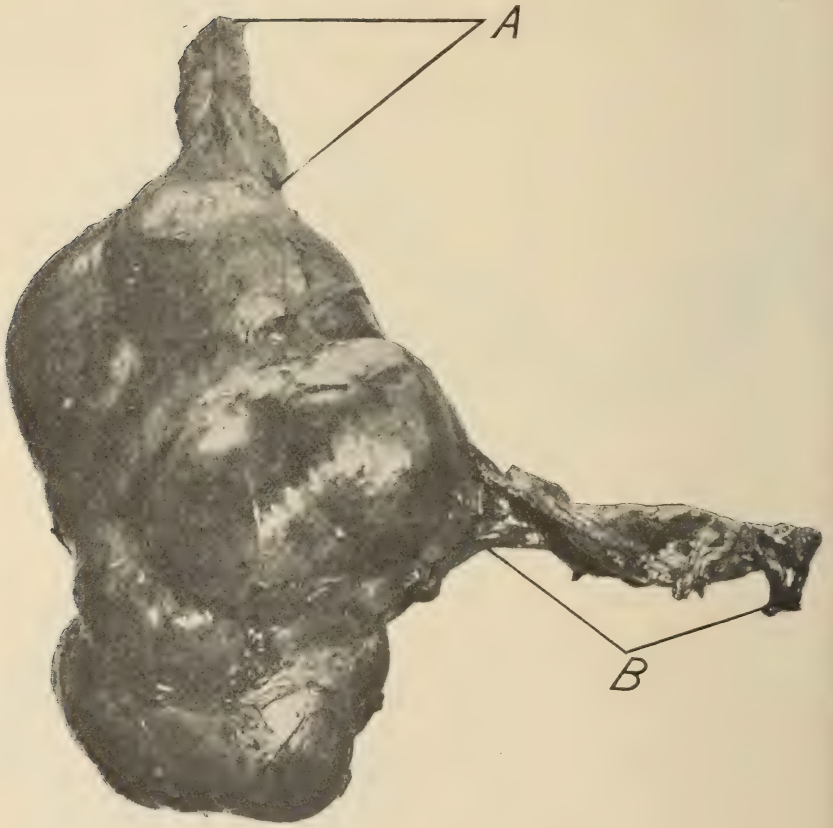


Anterior View.

A, Cervix ; *B*, Right Ovary and Tube ; *C*, Uterine Cavity.

To illustrate "A Complicated Case of Fibromata Uteri," by Nathaniel W. Emerson, M.D.,
page 639, *HAHNEMANNIAN MONTHLY*, October, 1899.

To face page 641.



Posterior View.

A, Cervix ; *B*, Right Tube and Ovary.

sufficient assistance. Had the assistants present not been unusually efficient, this tale would have had another ending. The patient's condition at the close of the operation was bad in the extreme. She was exhausted before the operation began, and at the end completely exsanguinated, and the chances of survival seemed very small. She rallied finely, however, and made a most rapid and satisfactory recovery.

At my request I was given the opportunity to keep her under observation, and for about two years after the operation she came to me three or four times a year in order that I might watch the changes, if any, in the fibroid. All abdominal tenderness disappeared, the tumor became quite freely movable, and she was without symptoms. In March of this year she came to me again, and upon examination I was surprised to find a very marked increase in the size of the tumor; it filled the whole pelvis, extending far to the right below and high to the left above, filling the abdomen. It was very irregular in shape, distinct bosses and sulci being easily demonstrable, and was only slightly movable. It was nearly two years since I had seen her. Her general health was beginning to fail, and while there was no serious hæmorrhage, there was at times a constant and disagreeable discharge of considerable proportions. As her age was only 33, and I knew of no way of controlling the rapid growth of the tumor, I advised immediate operation. The latter was undertaken on April 6th last.

An incision a little to the right of the former one was made into the abdominal cavity, which discovered a multiple fibroid lying as previously described and adherent throughout its whole surface. There was no slightest part of it which did not have contiguous organs most densely adherent to it. From above and from either side the intestines were separated from the tumor, always with difficulty and followed by profuse hæmorrhage, capillary in character. Below and in front the bladder was distributed in a most irregular manner, and was so densely adherent that, in spite of the utmost care, it was extensively opened in two places at a considerable distance from each other. Also, one of the larger tumors had pushed so far to the right that no broad ligament could be demonstrated until after it was enucleated. The remaining ovary was as large as a hen's egg. The tumor was finally enucleated,

separated from the vagina and removed. The openings in the bladder, one of which would easily admit two fingers, had allowed the whole lower portion of the wound to be suffused with urine, and the parts could not have been in worse condition for such a complication, there being no end of pockets lined with raw and shredded tissue. The openings into the bladder were painstakingly closed by, first, a row of sutures of fine catgut, which accurately coaptated the margins of the mucous membrane but did not penetrate the latter, followed by a second row of sutures of the same material carried into the muscles of the bladder so as to incurve and firmly cover and support the first row. All bleeding points were given most careful attention. Long before this the patient's condition was precarious; the hæmorrhage had been so excessive that no pulse could be found at the wrist, and several times it certainly seemed as if she could not be taken off the table alive. An intravenous injection of over two quarts of normal salt solution markedly improved her condition, which even then, however, was so sensitive that the change from Trendelenberg's position to the horizontal caused cessation of breathing, and for two or three minutes it seemed as if she were lost. She was immediately restored to the former position, and brought to the horizontal by easy gradations while the abdominal wound was being closed. This was done by through and through sutures of silkworm-gut, after the introduction of a double drainage-tube, which was conducted into the lowest cavity of the abdomen. A strip of gauze drainage was also carried from above downward into the vagina and a self-retaining catheter was placed in the bladder. She rallied most satisfactorily later in the day, and made a slow but steady recuperation the first three or four days, and more rapidly after that. There was a profuse oozing both by way of the vagina and through the drainage-tubes, which was, however, expected, and caused no apprehension. The bladder drainage was perfect, and continued for five days, when both the bladder and urethra became so irritable that the catheter was removed, and at first thereafter she was catheterized every two hours throughout the twenty-four. This time was soon lengthened to three, and afterwards to four hours without discomfort. There was no leakage through the ruptures in the bladder, and they evi-

dently healed by first intention, there being since no uncomfortable bladder symptoms. The tubes were shortened about an inch on the second day, and then every two or three days, until entirely removed. The abdominal wound closed without complication, and the recovery is at present satisfactory in every respect. Of course, from six to eighteen months will be necessary for complete recuperation.

A FATAL CASE OF PURPURA HÆMORRHAGICA; WITH A STUDY OF ITS DIFFERENTIAL DIAGNOSIS.

BY FRANK H. PRITCHARD, M.D., MONROEVILLE, OHIO.

THE clinical signs and symptoms in purpura hæmorrhagica appear at first sight so striking and typical that it would seem that once the typical spots be seen, then the diagnosis is settled. But upon further consideration of the subject it strikes one that there is really more in it than at first appeared.

Out of the numerous diseases with associated purpuric phenomena, Werlhoff, in 1775, separated and first described a disease which was later named, after him, morbus maculosus Werlhoffii, or our hæmorrhagic purpura. Later other varieties were distinguished as purpura simplex, then purpura urticans, and finally, on Schoenlein's authority, purpura rheumatica or peliosis rheumatica. Holding, as is generally done to-day, with Litten,* that these various clinical entities, so subtilely differentiated by our forefathers, are rather the same disease, but differing only in degree or intensity, yet on examination it is seen that, though they may be of very different origin, it is convenient to arrange them under the heading "Purpura." Strictly speaking, purpura is not a disease, but a symptom. Dr. Stephen Mackenzie, in his admirable address at the meeting of the British Medical Association in Liverpool in 1883, classified purpura under vascular, toxic, mechanical and neurotic purpuras.† Yet this arrangement is not as broad and comprehensive as that of Osler,‡ who divides it into :

* *Die Krankheiten der Milz und der Hæmorrhagischen Diathesen*, p. 343, Vienna, 1898.

† *Diseases of the Skin*, by T. M. Anderson, 1887.

‡ *Practice of Medicine*, p. 316, 1892.

Symptomatic Purpura.—(a) *Infectious.*—In pyæmia, septicæmia, malignant endocarditis (especially in this latter affection), typhus fever, measles and scarlet fever, and more particularly in small-pox, each has a purpuric variety, and typhus always is purpuric.

(b) *Toxic.*—The virus of snakes, certain medicines, particularly copaiba, quinine, belladonna, mercury, ergot and the iodides, occasionally are followed by a petechial rash. The purpura associated with jaundice, too, comes under this division.

(c) *Cachectic.*—Tuberculosis, cancer, Bright's disease, Hodgkin's disease, scurvy, and old age, have been noticed to develop purpura.

(d) *Neurotic.*—Myelopathic purpura, complicating ataxia, in acute and transverse myelitis as well as in the acute form, have been described. The stigmata of hysteria, or bleeding points, come under this class.

(e) *Mechanical.*—Seen from venous stasis of any form, as in the paroxysms of whooping-cough and epilepsy.

Arthritic Purpura.—Purpura simplex, seen particularly in children.

(f) *Peliosis Rheumatica.*—(Schoenlein's disease.)—With purpura urticans, pemphigoid purpura or febrile purpuric œdema, and Henoch's variety of purpura, as subdivisions.

Purpura Hæmorrhagica.—With purpura fulminans as an intense form.

About June 1, 1899, I was consulted at my office by a young lady of twenty-two, of somewhat delicate build, fair complexion, and a dressmaker by occupation, who told me a story of overwork, and with regard to some purple blotches which had appeared on her arm and face. A slight greenish discoloration on her left lower jaw, and one of the size of a fifty-cent piece, recent and purple, were noted. Her arm had a few scattering red petechiæ dispersed here and there. Though she asserted that she had no others on her body, and had been well to within a few days, I afterwards learned from her parents that she had been out of health since the preceding March, and that her thighs, legs and feet were covered with numerous large purpuric blotches and petechiæ, as well as vibices. I saw her twice at intervals of a few days, and administered *arn.*, *hamal.*, internally and externally, without success, though only two new spots appeared on her left arm near the first, which was undergoing absorption.

At her third office visit she looked so ghastly and anæmic that I immediately sent her to bed. Before that she had had no gingival hæmorrhages, but had begun then to bleed from her gums. On account of her assuring me that these blotches on the arms were the only ones, I had not sent her to bed, but recommended her to keep quiet.

When seen the third time her pulse was soft, full, and somewhat rapid, her tongue bloody, with a few strings of clotted blood on the tip, her appetite poor, her bowels normal. I found the spleen and liver normal in size. Her blood was thin, reddish-pink, of the color of strawberry juice, the blood-corpuscles (red) running together in rouleaux, but quite colorless. There was no great number of leucocytes. Her gums were not spongy, ulcerated nor soft, nor was there any fetor of the breath, though this became intolerable late in the disease and a few days before death. Yet there were parts of the gums which were hæmorrhagically infiltrated but not particularly soft. The teeth were not loose. There was no murmur at any orifice of the heart. Beyond a soreness in the left shoulder-joint, which ached quite considerably, there were no rheumatic symptoms, though ten years before she had had a severe attack of rheumatic fever, followed by chorea. The spots were not grouped about the joints. This condition was present the next day, and during the night following that day, towards morning, she vomited a bloody fluid and passed two blackish and tar-like stools, after which she felt relieved. Her temperature at first was one and a half degrees below normal, but after a day in bed it rose to normal, and at times would be one or two degrees above. On the second day in bed she began to flow, as it was her regular menstrual period, but rather profusely. There was no nose-bleed. The conjunctivæ were not injected nor bleeding. Her pupils reacted slowly to light. She began to complain of slight headache, which persisted and gradually increased in severity. The pulse kept up well, and was of good volume though rapid. The following night she had an attack which resembled a slight stroke of apoplexy, which in a short time passed off; there was helplessness and numbness of the right side of the body and tongue. She was rational, and though weak was in her right mind. The remedies ferrum phos. 3x and phos. 3x having no effect, fl. extr. secale c. and

arom. sulphuric acid, āā 1 drop, were given hourly. The hæmorrhages were controlled gradually by these drugs, so that in a day and a half they had ceased. But the weak general state continued, became aggravated, in spite of nourishing food, as beef tea, beef extract, milk, water and fluid foods, given every two or three hours. A second hemiplegic attack came over her, but it passed off quickly, like the first. Though there was no colic, she vomited quite a good deal towards the last. A consultation with Dr. Burt, of Norwalk, was held, who confirmed my diagnosis. We went over the different possible affections, and, after examining the blood, narrowed it down to purpura hæmorrhagica. The patient gradually became weaker, at times delirious and unconscious, finally passing into more or less complete coma, though at times she appeared to recognize her relatives. Her pulse kept up well and full, but in the last twenty-four hours it failed rapidly. A fatal ending was predicted. Now and then a sinking attack or vomiting of dirty brownish and foul-smelling fluid would occur. Her face was drawn and emaciated, and so strikingly pale and corpse-like as to startle one on going into the room; but with all her sufferings and loss of blood her body and extremities remained plump. The breath was intolerably fetid, her gums blanched, firm, and in spots hæmorrhagically infiltrated. The tarry stools and breath had a rank and stinking smell like of lochial blood. The urine was not tested at first, and as she soon began to menstruate I could not get a clear specimen. It was not bloody at first, nor later, so really there was no hæmaturia, nor at any time nose-bleed. Later the urine was found to contain quite a quantity of albumin, but both Dr. Burt and I regarded this rather as a transudate, on account of the dyscrasia. After two and a half days of unconsciousness she died of exhaustion, but without signs of hemiplegia.

Pernicious anæmia was excluded by the erythrocytes being normal in form, though there were a few red corpuscles of smaller size than normal, but there was no poikilocytosis nor intense redness of the remainder. It is stated by Clifford Albutt* that this variety of anæmia may be complicated by such a symptom-picture like purpura hæmorrhagica with bleed-

* *System of Medicine*, vol. iv.

ing gums, though it is rare; this is not mentioned by the majority of writers.

Hodgkin's disease, or pseudo-leukæmia, was cast out on account of the lymph-glands being normal in size. Albutt also admits that, though rare, purpuric phenomena may be associated with this affection.

The various infectious diseases were thrown out, as there was no history to warrant my considering them, though her earlier rheumatic history strongly favored my leaning towards something on that order as a pathological basis.

Cerebro-spinal meningitis had been observed, a few cases, in a neighboring town, but the previous history, the course of the disorder and the lack of brain and spine symptoms rendered that improbable.

No drug, as far as I could learn, had been taken which would bring about such a state of the blood.

Leukæmia was excluded, as the examination of the blood revealed no abnormal number of leucocytes nor any of abnormal size. Besides, her spleen and liver were not enlarged.

Endocarditis was not probable, as no murmur was audible at any orifice of the heart, nor was there any pain connected with the spots, as in lodgment of emboli. Neither did the other symptoms tally.

Scurvy gave me a little trouble to reject at first, on account of the gums bleeding; but they were not spongy, ulcerated, nor was there any odor from the mouth until very late in the course of the disease. Though hæmorrhagically infiltrated, the gums were firm; and while covered with bloody crusts, in places, on removing them the gum itself was not ulcerated. This point is not sufficiently dwelt upon in the text-books. Anderson* states, in differentiation, that the gums in purpura are healthy, while in scurvy they are not. This is seemingly not always true.

"*Scorbutic anæmia*" of the English writers is practically pernicious anæmia, with gingival hæmorrhages, so that was thrown out with the latter by the blood being practically normal.

No violent emotion had preceded, as I could find out, so hysteria could be excluded, and there was no analgesia of the skin.

* *L. c.*

Dr. M. Conan* quotes Van Swieten on a case of purpura hæmorrhagica at each menstrual period in one case, and in another case purpura following a violent emotion,† while several examples are given by Litten.‡

Peliosis rheumatica was somewhat close in some ways on account of the history, but the malignancy was rather against this acceptance. Especially did *arthritic purpura with gastro-intestinal and renal manifestations* resemble it, though this usually occurs in children, and it is a not uncommon, but little recognized form, and sets in usually with pains, but rarely with much swelling of the joints. Purpura or purpura urticans develops about them, and the case at first looks like one of so-called rheumatic purpura. Soon other symptoms develop; the child has attacks of severe colic, with vomiting and diarrhœa; true gastro-intestinal crises, which may recur with great frequency, particularly at night. There may be hæmorrhages from the bowels, and, soon, renal symptoms. There are albumin and tube-casts, often blood in the urine, and sometimes all the symptoms of an intense hæmorrhagic nephritis. The cases may drag on for months. Death may occur from the nephritis or from the severe gastro-intestinal disturbance. Couty, who has given the best description of this affection, regards it as a form of nervous purpura. This form has an interesting connection with the angio-neurotic œdema, which is also characterized by severe gastro-intestinal crises. Of four cases which Osler had under his care, one died of the nephritis.§

In my case there was no colic and no hæmaturia. The only joint involved was the left shoulder articulation. Though similar in many ways, it hardly fits my case's symptom-picture.

Dr. Anderson|| records a case similar to mine. A mining engineer, aged 27, who had previously enjoyed good health, but who had lost a brother of phthisis and a sister of "softening of the brain," began to complain of debility, "weak stomach" and constipation, the result, it was supposed, of hard work and irregularity as to his meals. His symptoms did not improve under treatment, and he was sent to Arran for change

* *Syphilis Universelle*, Paris, 1894, p. 354.

† *Bulletin Médical*, No. 8, 1894.

‡ *L. c.*

§ *L. c.*

|| *L. c.*

of air. On Friday, the 16th of August, while there, his eye became ecchymosed, when he immediately went home. When he saw him, on Monday, 19th, copious extravasation of blood was observed beneath the conjunctivæ and around the eyes, while small purpuric spots, which had only appeared on the morning of my visit, were detected upon the legs. His gums were bleeding, he had slight hæmorrhages from the stomach and bowels, and the urine was bloody. Two days afterwards he died. Under castor oil and turpentine the hæmorrhages from the mouth and kidneys became much less, but never altogether ceased from the stomach till a few hours before death, up to which time the retching and vomiting of altered blood were very persistent. Although stimulants were given very freely, exhaustion came gradually on, accompanied by delirium.

APPENDICITIS: INDICATIONS FOR OPERATION.

BY CARL V. VISCHER, M.D., PHILADELPHIA.

(Read before the New Jersey Central Medical Society, July, 1899.)

HAVING been asked to present to you a short practical paper, and in thinking over various subjects that are of such character, none have impressed us with greater importance than the timely recognition of appendicitis and the indications for operative treatment.

The subject has been so exhaustively discussed that it may appear superfluous to add to the already voluminous literature. From a no-inconsiderable experience, however, we have been led to recognize certain signs that have proven so characteristic and positive in their indications for operative interference that we feel it our duty to impress them upon those who, perhaps, do not see these cases quite as frequently, especially as we have oftentimes had it forced upon us that the indications for operation have not been sufficiently specified.

It is scarcely necessary to enter into the diagnosis of the disease, as we feel confident you are all familiar with the characteristic picture, and which rarely leads to confusion with other changes, particularly not in the acute forms, in which it is so

essential to institute the proper treatment. It may, however, be well to briefly compare appendicitis with the three diseases with which it is most likely to be confounded when acute.

In the female, acute salpingitis or ovaritis is ushered in similarly; the subjective history, however, will usually reveal a state of sexual ill-health for some time past. We would like to call your attention here to a clinical experience that has been repeatedly verified, *i.e.*, that the tendency is rather to favor tubal trouble; and as it is the less dangerous of the two diseases, in so far as life is directly concerned, we should here, as elsewhere, suspect the more serious. Especially is this error common for the reason that we find appendicitis frequently developing a little before or just after the menstrual flow, a coincident that has not to the best of our knowledge been before noted, and can, I believe, be explained in part at least by the vascular relationship of the appendix to the ovary. Subjectively there will also be less tendency for the pains to come paroxysmally, they being more continuous, and accompanied from the beginning with a persistent nausea. The temperature is inclined to be higher, as in appendical trouble it is rarely above 102° ; in fact a higher temperature, except at the very beginning and in children, is looked upon with suspicion. The pulse is in proportion to the temperature until late in the disease, after peritoneal involvement has taken place. Physically we find the area of pain lower in the abdomen, and very often on both sides, as in a great many of the cases of tubal inflammation the disease is bilateral. The tenderness on palpation is not accompanied by the early and marked muscular resistance that inflammation of the appendix shows; digital examination, per vaginum, reveals the enlarged tubes; or very early in the disease, where this is impossible, the vaginal vault will be tender, as will any movements of the uterus. The rectal examination also will elicit more tenderness than is often found in appendicitis. It must also not be lost sight of that at times appendicular inflammation complicates tubal trouble. In these instances, as in the latter stage of each disease, when peritonitis has set in it may be extremely difficult or even impossible to differentiate, the indications then for operation are so obvious that a positive diagnosis is not necessary, as the treatment resolves itself much on the same principle.

Biliary Colic.—This is a trouble most often found in women; and whereas men are by no means exempt, the proportion is greater than it is in appendicitis, where some few years ago it was claimed that women were rarely the victims of the disease under discussion. Experience has taught us, however, that this was not the case; so that, whereas we grant that the percentage of women attacked is less than of men, the difference is not as large as in gall-stone disease. This, too, is of sudden onset, and as a rule lasts but a few hours, not to be repeated for some days, or perhaps indefinitely postponed; the condition accompanying the passage of a gall-stone is one approaching collapse, and is never seen in appendicitis save late after the rupture of an abscess. When a stone leads to an infection, that is, an inflammation, which is suppurative in character, it is accompanied by symptoms that can scarcely be compared in their acuity to those of appendicitis. The pains of cholelithiasis, though at first, as in inflammation of the appendix, referred to the stomach, radiate toward the right hypochondrium and through to the back. Later in the disease the bladder, unless the patient be very corpulent, can be mapped out, if not distinctly at least with some degree of muscular resistance, and above a line drawn transversely through the umbilicus the tenderness will be found to increase in an upward direction, whereas in appendicular trouble, even when the appendix lies upward, the tenderness will be found to increase in the opposite direction. The temperature is not specially important, save that it shows a septic process. The entire course of the disease is more sub-acute in character.

In renal colic of the right kidney we have a similar commencement to the above trouble, and as a rule the pains are more severe, the emesis being, however, not as persistent, the pains radiating along the course of the ureter down the inner portion of the thigh and to the testicle. We are also apt to have dysuria, hæmaturia and a decrease in the quantity of urine; more seldom complete retention, which, by the by, may occasionally be met with in appendicitis. The general condition of the patient, as in gall-stone colic, tends towards collapse, and it is only after secondary changes begin that we have evidence of any inflammation. At this stage it is not difficult to make a differentiation.

As to the symptoms to be relied upon in coming to a conclusion of appendicitis, they are: Abdominal pain that is usually paroxysmal for a variable length of time, and which is at first referred to the epigastrium or umbilical region, gradually becoming more and more localized as the inflammation progresses in the right iliac fossa. With this cramp there is commonly nausea or vomiting, which does not persist. It even may pass away entirely, only reappearing late in the disease as a sign of peritoneal involvement. The tongue is more or less heavily coated with a white fur; the pulse is proportionate with the temperature, which varies from normal to one hundred and two. A chill, which is so often looked for before operation is thought of, is rather the exception than the rule, so that its absence is of no significance, being found generally in those cases where the suppuration has become localized. The bowels may be either of the two extremes, constipated or diarrhœic; usually, however, the former. Thus it is seen that none of the above symptoms lead to a certainty in forming a conclusion as to the proper course of treatment to pursue. Upon what, then, shall we depend for a guide? It is rather dogmatic to say that every case of appendicitis, as soon as diagnosed, should be operated at once. Who, of any experience whatever, will gainsay that this is not the safer extreme? The rule to subject every case of appendicitis to operation at the end of thirty-six hours, unless signs of decided improvement are present, is undoubtedly a good one, and should an error occur, it would be by great odds in favor of the patient. In spite of these rules, each case is a law unto itself, one being best operated immediately the diagnosis is made; in another it may be well to wait a day, perhaps two, and possibly longer, depending not alone upon the case, but also on circumstances, as many times it is advisable to see the patient through the acute attack, and then the removal of the appendix may be done with much greater safety during the period of quiescence, when the general condition of the patient will bear surgical intervention better.

We have learned to depend upon certain signs which, when present, always indicate operation. To the subjective symptoms we pay little or no attention, but at once inspect the abdomen, and, if the case is progressing from bad to worse, we notice a slight distention with a general sensitiveness. This universal tenderness must not mislead us, and if the appendical

region is carefully palpated it will be found to be most marked here, even at the very beginning of the trouble, and increasing until it becomes so exaggerated as to have been described as "exquisite;" in fact, the patient flinches by simply pointing to it. In addition to the tenderness there is *muscular rigidity*, a sign of the *greatest* significance, and one which will be found in every case of acute inflammation of the appendix, and becomes more marked in proportion to the severity of the inflammation up to a certain point, *i.e.*, when an abscess either ruptures or springs aleak; it will then decrease more or less suddenly, and is of bad omen. With the increased tenderness and rigidity we find an increase of the pulse-rate. The temperature may range from normal up to one hundred and two, and, in our personal experience, is of little value. Rectal examination, though a routine custom with us, has rarely proven of avail, save in differentiation from uterine or tubal disease. Finally, the facial expression, which we find gradually assuming the Hippocratic, and is in proportion to the severity of the disease. We can thus classify the symptoms for practical purposes in order of their importance as follows: Muscular rigidity, tenderness, facies abdominalis, rapid pulse. Where these exist an operation is always indicated, and is by all means the safer procedure. On the other hand, if none of these are or have been present, our experience teaches that it is safe to treat the patient medically. It must, however, be borne in mind that the sudden, or at times even the gradual cessation of these signs is of the utmost importance, as it may mean the beginning of a septic or suppurative peritonitis. Therefore we should desire to impress upon you that, these signs once having been present, the abdomen should be opened and the appendix removed. It may be noticed that nothing has been mentioned of the presence of a tumor nor of dullness on percussion, and purposely so, for the reason that neither are of any value. Tumor formation is only found in the more exceptional cases, and percussion dullness is not always then present, for the reason that the cæcum is usually interposed between the abscess and abdominal wall; therefore, when these two signs are present it becomes obvious, for other reasons, that an abscess has formed, and no further guide need be mentioned; but it must be remembered that one is in no way justified in waiting for either before deciding in favor of operation.

THE LOGIC OF SIMILIA.

BY R. B. LEACH, M.D., ST. PAUL, MINN.

LOGIC is the science of the operations of the understanding which are subservient to the estimation of evidence; both the process itself of advancing from known truths to unknown, and all other intellectual operations in so far as auxiliary to this.

Similia is the art of healing the dynamically indisposed through the interposition of a drug potency or other medication characterized by signs and symptoms the similitude of, but not the same as, those produced by the curative agency in well persons.

The logic of similia comprehends, and by right should and does exact, an understanding, knowledge and estimation of the mental, moral and material exhibition of the law of similars; or cognizance or clear and certain perception and indubitable information of *similia similibus curantur*.

The logic of similia exacts a comprehension of the physiologic as well as the pathologic state of man or beast (according to the domain of our practice) and a knowledge of drug pathogenesis ("known truths"); but above all this an understanding of the law governing the alleged ("unknown") curative and the equally alleged ("unknown") prophylactic.

The logic of similia exacts a repetition of the indicated remedy at short or at long intervals, according as the character of the malady prescribed for (the "unknown") is of the rapidly fatal (cholera) or of the chronic form (syphilis), as well as according to the "known" potency of the curative agency exhibited.

The logic of similia should be the most, instead of (as at present) the least, conspicuous daily didactic (as well as practical) demonstration of our law of cure in the curriculum of more of the institutions of learning claiming allegiance to Hahnemann, and to this, his greatest, discovery and promulgation.

The logic of similia can be acquired in no institution, however denominated, except through the daily unfolding of the law, so that those seeking it may be brought, "not as in a glass, darkly, but face to face" with visible as well as with those results insinuated in the accepted appellation of their preceptors: homœopathist.

The logic of similia admonishes against hypocrisy (the blackest crime, next ingratitude, known to man), synonymous, in the case of a non-homœopathically instructed "homœopathic medical college," with "obtaining money under false pretenses;" which interpretation cannot be too quickly nor too vociferously abrogated by a suspected faculty.

The logic of similia (like any other reasoning from effect to cause) necessarily excludes double remedies (in alternation or in mixtures) and discountenances the physiologic dose, for no "proving" illumines the dubious pathway of mixtures or of alternated curative potencies, and the law is never exemplified through the primary effect of the crude drug.

The logic of similia demands appreciation of Hahnemann's *Organon* (which is the only logical first source of similia), of his *Materia Medica Pura*, and of his *Chronic Diseases*, for therein obtains, as evidence for estimation, the incontrovertible proofs of the mental, moral and material exhibitions of this law, as well as those rules and regulations which, agglomerated, comprehend the law.

The logic of similia demands more living examples of homœopathic thought and practice (according to the law of the method of cure and prevention enunciated in the writings of Hahnemann), less haphazard and crude prescribing by present-day preceptors, and no encouragement for the so-called "homœopathic pharmacy" that advertises "homœopathic mixtures" which have not and cannot have any existence in fact.

The logic of similia should never be deemed by an instructor in a homœopathic medical college as in any way possibly inimical to the best interests of said institution; and any instructor advising to the contrary should be promptly released from his, at least implied, obligation (and office), and the true as well as the implied principles of that institution be at once and un-

equivocally announced, that no prospective patron may be mistaken in its homœopathicity.

The logic of similia can entertain in no position of trust, honor and example, him whose prescriptions are but equally "homœopathic" in principle to those of his allopathic colleagues who practice "either way;" for it is this lack of appreciation of similia, more than any other one thing, which jeopardizes the integrity and future of our cause and makes our law the butt of a deserved ridicule by those not at all responsible for and equally ignorant of its blessings.

The logic of similia demands, in self-preservation, a rigid adherence to the single, true law for the healing of the non-surgically sick in the speediest, gentlest and most permanent manner; the diurnal delving of every student of similia into the rich stores of profound and erudite researches of the many truly great disciples of Hahnemann, and a sufficient appreciation for human life to offer only our very best; which can never include nor countenance illogic speculation.

TROPON—A MAXIMUM NUTRITION AT A MINIMUM COST.—It is to the forced feeding of patients in phthisis that actual progress counts in combating this disease. Any substance or combination of food elements which would furnish concentrated and complete nourishment in malnutrition merits consideration.

Tropon, containing 90 per cent. pure albumin in the ultimate form of its absorption, must be reckoned a valuable contribution to food chemistry and food digestibility. When nutrition is deficient on account of exhaustion from disease or overwork, Tropon supplies nutritive material, and it can be readily adjusted to a mixed dietary. It does not impair normal digestive vigor nor induce the aversion and monotony arising from the exclusive use of other food products. It is capable of insuring prolonged and sustained nutrition, *per se*. It is a perfect and complete substitute for albumin in ordinary food. The clinical experiments of Finkler have shown that it is best used as an adjuvant with other food. It is palatable, well borne, and does not cause intestinal disturbances. On account of these advantages, also its small bulk and low price, it should achieve the same measure of success here as in Europe.

Strauss and Plaut of Berlin, Klein and Schmëliniski of Hamburg, and Rumpf of Gorborsdorf, give unstinted praise to Tropon as an unrivalled food value in the various processes of digestion, absorption and assimilation, all reporting a rapid increase in weight from its use. Knopf of New York, in his recent work on *Pulmonary Tuberculosis*, page 241, says: "Of the many food substances which have been recommended recently as especially valuable in the dietetic treatment of tuberculosis, I have used most extensively, and with most satisfactory results, the new product, Tropon."

EDITORIAL.

WM. H. BIGLER, A.M., M.D.

WM. W. VAN BAUN, M.D.

EUTHANASIA.

AN address lately delivered by Judge Simeon E. Baldwin, of New Haven, before the American Social Science Association at Saratoga, has attracted widespread attention. In it he discussed the right of the incurable to a natural death not protracted by medical skill. He does not advocate hastening the death of one for whom there can be no reasonable hope of recovery, but thinks that the rights of such a one to a natural death are infringed when a hopeless, useless and painful life is prolonged by medical intervention. He does not speak, therefore, so much for an active shortening of life as for a passive attitude on the part of the physician in view of inevitable death.

The question is one which is liable to confront any one of us at any time, and is, therefore, of more than mere theoretical interest. In the abstract it is perhaps more easily answered than in any particular concrete instance, on account of the uncertainty attending almost every prognosis. In many cases where there has been no reasonable hope of recovery, by some strange freak of Nature recovery has taken place in spite of the correctness of the diagnosis, while in still more, the hopeless prognosis of one physician has been proved by another's successful treatment to have been based upon an error in diagnosis. There remains, however, a certain number of cases which are universally regarded as hopeless, and tending to a fatal issue within a tolerably definite time. In some of these it seems possible by medical interference to put off for a longer or shorter period the inevitable result. To these, under the criticism which met his first rather ambiguous utterances, Judge Baldwin wishes the application of his remarks to be limited.

We think the whole question has been obscured by incorrect views as to the relation which the individual bears to society and to himself. It should be conceded that a man's life belongs to himself, is his very own, a possession which under ordinary circumstances he prizes above all else, and to which he clings with instinctive tenacity to the end. Self-preservation is the first law of nature. He has not only not received this gift from society, but, in the case of those born in abject poverty, has it almost in spite of existing social conditions, and is therefore in no way accountable to society for the disposition he may make of it. So far as society is concerned, he may keep it or lay it down without incurring blame, and, to our mind, nothing can be more irrational or unjust than to punish an unsuccessful would-be suicide, or, *post-mortem*, to mutilate or to deny ordinary burial to the body of one who has succeeded in his purpose, as was formerly done according to law. With his accountability to his Maker we have nothing to do. Neither the conditions surrounding life nor the consciousness attending its possession give an inkling that it is anything but a free gift, of the value of which the possessor is presumably the best judge.

The right of an individual to his life is partly recognized in that we consider it the highest crime to deprive him of it, but the full right to keep it or to surrender it is but seldom conceded, although a suicidal deed of heroism, a surrendering one life for another, is applauded, whereas it should be condemned if man does not possess full and complete right to dispose of his life as he will.

If, therefore, by reason of irremediable suffering and incurable disease, life has become a worthless, or even a burdensome possession to an individual, it is his inalienable right to be allowed to surrender it. His wishes should be respected by the physician, wherever there is no doubt as to the absolute impossibility of recovery. The physician will be doing his whole duty if he direct his efforts, not to prolonging life, but to making death easy. So long, however, as the patient clings to life, he should be consoled with evidences that all possible efforts are being made to prolong it.

So far we can go in the present state of public opinion, both abstractly and in practice; whether we can ever hope in the

future for such a change in the law and in our notions of morality as to allow physicians, with the consent of the one concerned, to shorten misery and incurable suffering in a human being, as we feel justified and called upon to do in the case of animals, time alone will show. We have all along maintained that we interfere too much in the workings of Nature in her endeavors to allow only the fittest to survive. We have before us, *apropos* of this subject, a clipping from the daily paper of to-day. Thomas M——, insane, is at present in the Hahne-mann Hospital with a fractured skull, caused by jumping from a second-story window. A few weeks ago he cut his throat, but recovered. Our false notions of humanity compel us to nurse and to care for him, not only with a view to relieve his suffering and to make him comfortable, but, if possible, to prolong his life—a life which is useless to its possessor, a burden and a menace to his family and to the community. Would not a more enlightened humanity restrict our efforts to promoting euthanasia?

The objectors to such a course are usually those who have no direct personal interest in the matter, and are akin in spirit to those bigots who have raised their voices against giving an anæsthetic to a woman in labor, because, forsooth, it was ordained that in pain should the woman bring forth. It was the will of Providence as expressed in the Bible. Consistency would compel these objectors to refrain from attempts to relieve all suffering and sickness, since their occurrence is only possible if in accordance with the same Will.

ANGIO-NEUROTIC ŒDEMA.

SEVERAL cases of this not very common, somewhat obscure, and very interesting disease, have been reported lately. It is characterized by circumscribed œdematous swellings in different parts of the body, disappearing usually in a short time, leaving no trace behind them in the parts affected. The lips, eyelids, face, larynx and hands, or, in fact, almost any part of the body may be attacked. We have found the lips and hands most often affected. In one case the entire body, and in another

the neck, was the seat of the disease, and in both of these latter cases, on several occasions, it attacked the larynx, with distressing symptoms of suffocation.

The swelling varies much in size, and the color of the skin may range from a pale waxy hue to a light or dark red. The well-defined œdematous spots are usually attended with a feeling of burning and itching, more or less intense. It may make its appearance suddenly without warning, although some slight gastro-intestinal disturbance is a frequent forerunner as well as accompaniment. The temperature is not invariably affected, but a slight rise is not uncommon. It occurs most frequently in adults, and we have met it only in females, contrary to the observations of Dr. Slifer (*Philadelphia Medical Journal*, July 29, 1899), who says it is oftener seen in males.

The most constant etiologic factor discoverable in our cases has been some nervous disturbance, either in the form of sudden shock or as the culmination of a period of continued worry. Even where the attack seemed to be traceable to some particular kind of food, it was only in connection with this nervous element that such was the case, for, under other conditions, the same article of diet could be taken with impunity.

We have not traced the influence of heredity carefully enough to estimate its importance. In one case, however, we recall that the female member of the family suffered from a sudden severe but transient attack, while her brother was subject to frequent attacks of ordinary urticaria, or "hives," as her father had been during his youth. We consider the disease closely allied to urticaria, with perhaps a difference only in the exciting cause.

It is only when the disease invades the larynx that it becomes serious, for deaths from suffocation have been recorded.

The remedies upon which we have principally relied and from which we have obtained the best results are belladonna and apis, while for the cases where the attacks were of frequent occurrence the salicylate of soda has seemed to be of special benefit.

The disease is an interesting one and will bear further study.

GLEANINGS.

EARLY TYPHOID NEPHRITIS; NEPHRO-TYPHUS.—Dr. A. Donnadien relates the case of a woman of twenty-four years, in which a nephritis set in at the beginning of a typhoid fever. The albumin reached four gms. to the litre; there was scanty urine, very pronounced dyspnoea, signs of pulmonary oedema, incessant vomiting, delirium, relatively low temperature. Little by little the renal trouble improved until only the symptoms of a simple typhoid remained. Then the temperature, which had been rather low, crept up to 38° and 39° (C.). Though admitting the frequency of albuminuria in typhoid fever, he thinks it usually slight, and rarely reaching such a degree, and with such intense symptoms, as in his case. Such a one, with early and intense renal lesions, deserves the name of a nephro-typhoid, analogous to the pneumo-typhoid, pleuro-typhoid, etc.—*La Settimana Medica*, No. 30, 1899. Osler—*Practice of Medicine*, p. 13, 1892, under the "Special Features and Symptoms"—mentions as a mode of onset, as an important deviation from the regular beginning, typhoid commencing with symptoms of an acute nephritis. Further on he treats of the renal complications:

1. Febrile albuminuria, which is very common and of no special significance. Thus, in the first 75 cases admitted to the Johns Hopkins Hospital, albumin was present in 46, and in 25 casts were found. In only *two* of these cases were there indications of an acute Bright's disease.

2. Acute nephritis occurring at the onset or at or during the height of the disease—the nephro-typhus of the Germans, the *fièvre typhoïde à forme rénale* of the French—may set in with all the symptoms of the most intense Bright's disease, masking in many instances the true nature of the malady. After an indisposition of a few days there may be fever, pain in the back, and the passage of a small amount of bloody urine. In a recent case the symptoms were early all those of the most severe nephritis, and death occurred on the fourteenth day, from perforation of the bowel. In other instances the nephritis sets in at the end of the first or second week, and may modify considerably the character of the disease, and even render the diagnosis doubtful.

3. The nephritis of convalescence. More common, but less serious. It develops after the fall of the fever, and is usually associated with oedema. It does not present characters different from the ordinary post-febrile nephritis.

As other varieties, the lymphomatous nephritis of E. Wagner and post-typhoid pyelitis, particularly the latter, are worthy of note. A recent writer has called attention to it as a possible cause of a rise of temperature after it has seemingly fallen definitely.

Frank H. Pritchard, M.D.

TREATMENT OF POISONING BY CARBOLIC ACID.—Dr. Harnsberger, in a young man of sixteen, who had swallowed fifty gms. of carbolic acid, and who, one-half hour later, was comatose, with an imperceptible pulse, etc., poured

a pint of cream into his stomach through a stomach-tube, and massaged his abdomen in order to mix the cream and acid well. The extremities were rubbed with dry, hot cloths at the same time, with the result that in two to three hours he became conscious. The cream was then continued at short intervals. In two days he was wholly restored. Harnsberger asserts that an adult may ingest fifteen gms. (one-half ounce) of pure carbolic acid without danger, if it be mixed with cream and glycerin or alcohol.—*Wiener Medizinische Presse*, No. 32, 1899. Vinegar has been recommended as an antidote to carbolic acid. As a chemical antidote, the sulphate of soda or Glauber's salt has been employed. Kobert (*Lehrbuch der Intoxicationen*, p. 226, 1893) advises injecting this salt in solution under the skin, in order to combine the free phenol circulating in the blood. Lime-water is better than pure water in washing out the stomach. At the same time he recommends giving freely of saccharated lime to combine with and render harmless the acid escaping into the intestines. Curiously enough, he advises a $\frac{1}{2}$ per cent. solution of carbolic acid as an antidote for irrigating the stomach, washing off affected spots of the skin, and to be inhaled in poisoning by bromine.

Frank H. Pritchard, M.D.

VESICAL ASTHMA.—This term is presented by Pawinski as a name for those attacks of dyspnoea in old men who, in consequence of hypertrophy of the prostate or other diseases of the genito-urinary tract, are not able to evacuate all the urine contained in the bladder at one time. He communicates five cases where simple catheterization and emptying of the bladder was sufficient to remove the dyspnoea. He is of the opinion that in these cases the dyspnoea is not reflex, but due to absorption of the ammoniacal urine, which is rich in bacteria.—*Berliner Klinische Wochenschrift*, No. 17, 1899.

MYELOPATHIC ALBUMOSURIA.—Drs. T. R. Bradshaw and W. B. Warrington treated a patient who for more than a year presented a great quantity of albumose in the urine, associated with thinning and friability of the ribs, sternum and vertebrae. Multiple myelomata were diagnosed, and the necropsy fully confirmed the diagnosis. The affected bones were brittle, filled in their centre with a soft mass consisting of round-cells; the denser shafts were thinned to mere shells. There was, further, a moderate degree of accompanying interstitial nephritis. Albumosuria is not observed in every case of lymphomatous bone-disease, yet its appearance indicates such a state.—*Wiener Medizinische Presse*, No. 32, 1899. Eichhorst—*Lehrbuch der Praktischen Medizin*, p. 336 (1899)—states that albumosuria may be recognized by heating the urine, and adding nitric acid when no precipitate forms, but on cooling one is thrown down. If it be heated again, the precipitate dissolves. Practically one may make the ordinary Heller's test (nitric acid test); if a ring form at the point of contact, it dissolves on heating the tube, while if it be albumin the ring becomes the more distinct if both albumin and propeptone (albumose) be present. Senator—*Die Erkrankungen der Nieren*, p. 10 (1896)—advises heating the urine and filtering out the coagulated albumin, when, on cooling, the albumose will precipitate.

Frank H. Pritchard, M.D.

FAMILIAL ALBUMINURIA.—Dr. P. Londe, of Paris, in eight persons affected with intermittent albuminuria, and belonging to six different families, found that in seven the disease was familial, or characteristic of the

family. What characterizes this variety is its insidious beginning and intermittence, as well as the disproportion between the digestive disturbances, headache, anæmia, etc., with the alteration of the renal function. It is probable that it is a disease of development of which only the benign form has been studied up to the present, but which also includes a more serious variety in which certain features of chloro-brightism intermingle.—*La Semaine Medical*, No. 33, 1899. Eichhorst states not frequently the day urine will in intermittent albuminuria contain albumin, while that of the night is free. Bodily exertion probably causes it to appear. Pavy (1885) first gave the name to this condition. It is most frequent in youths, so that Moxon has called it "the albuminuria of adolescents." It is most often noted in anæmic individuals. It has been observed that gouty families present such a tendency.

Frank H. Pritchard, M.D.

HÆMORRHAGIC NEPHRITIS AS A MANIFESTATION OF A GENERAL INFECTION.—Dr. Peter F. Holst, of Christiania, Norway, from three cases of acute hæmorrhagic nephritis asserts that there is a form of this variety of renal inflammation which is the expression of a more or less latent infection of the blood. The first case only at the necropsy revealed itself to be a generalized streptococci infection, for these germs were detected in the blood, liver, kidneys and spleen. The disease had lasted about eight months, and had fully simulated a hæmorrhagic nephritis. Only during the last weeks was it, and possibly in the beginning, wholly afebrile.

In the second case, which was wholly feverless, besides the nephritic symptoms there were signs indicating a recent endocarditis. In the blood, during life, the staphylococcus albus was discovered, which could be grown in cultures, though not in abundance, from the excrescences on the mitral valve.

In the third case, which left the hospital uncured, where the patient had probably suffered for a long time from a compensated valvular defect, the symptoms of an acute nephritis suddenly set in with great violence. The urine furnished pure cultures of the staphylococcus albus.

Based on these three cases, the writer claims that frequently a general infection, clinically speaking, assumes the mask of an acute hæmorrhagic nephritis. He insists upon the close relations between endocarditis and acute nephritis, and concludes that :

1. Acute hæmorrhagic nephritis is, more frequently than is now generally admitted in practice, the expression of an infection of the blood, or in other words of a latent pyæmia, or of a septo-pyæmia.

2. The transitory hæmorrhagic exacerbations which are so often noted in the course of a chronic nephritis, possibly in many cases may be due to a temporary infection of the blood (septo-pyæmia). Perhaps there may be a recrudescence in valvular affections of a hæmorrhagic nephritis similarly to the recurrent lighting up of inflammation in the endocardium. Thus one may speak of a recurrent hæmorrhagic nephritis as one speaks of a recurrent endocarditis.—*Norsk Magazin for Lægevidenskaben*, No. 7. 1899. Axel v. Bonsdorff, of Helsingfors—*Nordiskt Medicins Arkiv.*, Hft. 3, 1899—in an experimental study on the excretion of streptococci through the kidneys, has found that wholly normal rabbits' kidneys do not allow these germs to pass through. Dr. Harbitz of Christiania, in a paper read before the Medical Society of that city, takes up this subject very thoroughly.—*Norsk Magazin for*

Lægevidenskaben, Nos. 4-5, 1899. Dr. Jens Bugge stated that during the past winter and fall a great number of cases of acute hæmorrhagic nephritis entered the medical wards of the Rigshospital. Its origin was apparently unknown, and the number so great that it seemed epidemic. Of interest were the cases of two children of the same family, five to fourteen years, where the disease set in seemingly without cause, simultaneously. From August, 1898, to the end of the year, thirteen cases entered with idiopathic hæmorrhagic nephritis. Ten were discharged cured, two improved, and one still remains there. Clinically in none were there signs of endocarditis, but three had old valvular lesions. The cause appeared to have been a general infection of the blood.

Frank H. Pritchard, M.D.

THE DIAGNOSTIC VALUE OF ENLARGED GLANDS IN THE SUPRACLAVICULAR SPACES AND IN THE GROINS AS INDICATING VISCERAL CANCER.—Drs. Soupault and Labbé think that the presence of enlarged glands in the groin or above the clavicle as indicative of abdominal or thoracic cancer is considerably overestimated, for if of oversize above the clavicle it may be due to tuberculosis or syphilis, though it may be cancerous (Troisier). Its presence alone is not certainly diagnostic of cancer of an abdominal organ. In the groin the glands may enlarge from an infection of genital or anal origin, or from one in the lower extremity.—*Journal des Praticiens*, No. 32, 1899. Much was made a few years ago of the value of enlargement of the supraclavicular glands in the diagnosis of abdominal or stomach cancer.

Frank H. Pritchard, M.D.

THE CLINICAL SIGNIFICANCE OF OXALURIA.—Williams (*Maryland Med. Journal*, May, 1899), reviews three cases and formulates the following general conclusions:

1. Whereas the appearance of oxalates in the urine—excluding their ingestion as foods—is due to a derangement of digestion or metabolism, this derangement probably has its cause in many cases in functional nervous irregularity, which may or may not produce general nervous symptoms, and if these be present they are not necessarily caused by the oxalates.

2. The condition causing the appearance of oxalates in the urine may produce symptoms closely simulating the constitutional symptoms of Bright's disease.

3. The excretion of oxalates by the kidney for a short while may occasion no local disturbance, but if continued may, by irritation, cause the appearance of albumin and casts with lessened urine, corresponding to the urinary symptoms of Bright's disease, and if unchecked may lead to permanent destruction of kidney tissue and true Bright's disease.

4. In all suspicious cases in which the nephritic symptoms are accompanied by the appearance of oxalates in quantity, diagnosis should be held in abeyance and the oxaluria overcome by appropriate remedies (especially strong nitro-hydrochloric acid), to exclude this as a possible cause of the symptoms before making a positive diagnosis and a necessarily hope-dispelling prognosis.

F. Mortimer Lawrence, M.D.

ACUTE ABDOMINAL SYMPTOMS DEMANDING IMMEDIATE SURGICAL INTERVENTION.—Richardson (Boston) says acute abdominal lesions cause more deaths than all other diseases that require surgical operation. The great

mortality is owing to delay in operation, and the chief reason why surgical aid is not called sufficiently early is failure on the part of the attending physician to recognize the gravity of early symptoms. A second reason is failure on the part of the surgeon, even when called early, to perform the necessary operation. Three classes of abdominal lesions must be considered.

1. Those in which hæmorrhage is the chief factor.
2. Those in which peritonitis is the chief factor.
3. Those in which intestinal obstruction is the chief factor.

The most fatal lesions are those which quickly produce extensive gangrene, as intussusception, mesenteric embolism, acute pancreatitis, and perforating ulcers. Hæmorrhage may cause death more quickly. Extravasations due to appendicitis and salpingitis are slow and easily localized. In rapid processes operation must be *immediate*, even in the slow, operation must not be delayed.

The value of initial symptoms must be carefully weighed. Pain is the most important sign in all the acute lesions. It varies in onset, intensity, and permanence. Upon the patient it produces grave effects, as shown by his face, which expresses suffering, anxiety, and shock. It must be differentiated from the acute functional pains of intestinal, renal and biliary colics, indigestion, and cholera morbus. In hæmorrhage it is soon followed by pallor, restlessness, feeble pulse, and low temperature. Simple faintness seen in severe abdominal pain cannot be mistaken for the shock of hæmorrhage. Pain with beginning sepsis has, in addition to the symptoms enumerated above, and styled by the writer "peritoneal shock," abdominal tenderness and rigidity. Vomiting also adds important evidence, though vomiting alone means little.

With the signs mentioned, the diagnosis of an acute lesion that needs immediate operation must be made at once. Pain, pallor, feeble pulse, low temperature, means hæmorrhage; with irregularities in menstruation and tender breasts, extrauterine pregnancy; after operation, internal hæmorrhage. Pain, shock, vomiting, tenderness and rigidity in males means appendicitis, even if the *pain, tenderness and rigidity are general*.

In women with history of gall-stones these symptoms mean acute cholecystitis; if any of the signs point to the gall-bladder, with history of uterine or pelvic disease; salpingitis if they point to the pelvis; with bloody stools they suggest intussusception; with circumscribed resistant coils, a local intestinal gangrene or an internal strangulation; with a symmetrical tumor in the lower abdomen, an ovarian tumor with twisted pedicle. On very rare occasions these symptoms are deceptive and mean nothing. Pain, vomiting, tympany and distention, without shock, mean simple acute intestinal obstruction, or a chronic obstruction suddenly becoming complete.

As a rule, a diagnosis as to the probable cause should be made exact enough to guide the surgeon to the affected side of the abdomen. That this is not always possible is borne out by the experience of the writer, when in several cases he has been led to the region farthest removed from the true seat. As to the urgency, hæmorrhage demands intervention the most strongly. Hardly less urgent are those lesions producing early intestinal gangrene, or leading to sepsis of the general abdominal cavity; slow extravasations, simple obstructions and the like may, from their uncertainty, justify delay.

In cases of doubt, exploration is indicated when the foregoing symptoms are

present. A small incision only is required; the moment the peritonæum is nicked an escape of blood, serum or pus will prove that something serious is going on. Should no lesion be found, the chances of recovery are but slightly lessened. For one unnecessary operation a hundred necessary would be performed, for one life lost a hundred would be saved.

In conclusion, the writer strongly condemns the practice of first magnitude operations being performed by the inexperienced, and by those so situated that in a lifetime's work they must always be inexperienced. When, however, intervention is practiced by men of a certain amount of skill and experience, after a careful consideration of the difficulties of a positive diagnosis and the probable disasters of delay, the result, whatever it may prove, can be attended with no just cause for regret.—*The Philadelphia Medical Journal*, September, 1899.

Gustave A. Van Lennep, M.D.

GONORRHOEA OF THE EXTERNAL GENITALS OF THE FEMALE.—Dr. A. B. Tucker, N. Y., remarks that there is scarcely any surface of exposed mucous membrane as abundantly supplied with glands and secreting ducts as the external genitals of the female. The glands in the connective tissue of the vestibule are the first to come in contact with the gonorrhœal discharge of the male. The ducts of Skene are a special point of attack; they lie within the meatus, near the floor, and on each side of the urethra; they are three-eighths to three-quarters of an inch in length, dividing into numerous small cavities at their upper extremities. When infected, the tissues surrounding the mouths of these ducts become œdematous and swollen, the pus burrowing up into the cavities, the infiltration of the sub-urethral tissue extending almost to the neck of the bladder. The treatment is by local applications only. The ideal drug in his experience has been thiol. The method of application is to take a fine filiform bougie, cover the tip with cotton, dip it in thiol, full strength, and pass it into the mouth of the duct. This is done every day until the discharge is almost entirely stopped; then every other day until no discharge can be squeezed from the duct. In treating the other points, a piece of absorbent cotton saturated with thiol is laid over the vestibule, and a napkin applied to keep it in place.—*American Gyn. and Obstet. Journal*, 1899.

W. D. Carter, M.D.

PERINEAL LACERATION AND ITS IMMEDIATE REPAIR.—F. C. Hammond, Philadelphia, in the *American Gynecological and Obstetrical Journal*, June, 1899, calls attention to the support which the levator ani muscles and the pelvic fascia give the pelvic viscera. A laceration or atrophy of these tissues favors downward displacement of the pelvic viscera. He says that "this point cannot be too strongly insisted upon, nor can it be made too clear that these are the structures of importance in giving support to the rectum, vagina, bladder, and uterus, and not the perineal body."

W. D. Carter, M.D.

THE USE OF PROTARGOL AS A SUBSTITUTE FOR THE NITRATE OF SILVER FOR THE PREVENTION OF OPTHALMIA OF THE NEW-BORN (Credé's method). (Engelmann.)—Darier recommended a 10 to 15 per cent. solution and observed no signs of irritation. Praun calls protargol by far the best prophylactic against bleunorrhœa neonatorum. Esman reports 277 cases treated with protargol—29 with a 2 per cent. and 248 with a 1 per cent. solu-

tion—and in only 20 per cent. of all cases were there inflammatory symptoms, which were so slight as to disappear in one or two days. He concludes that protargol is less irritating and more effectual than nitrate of silver. One hundred consecutive cases were treated by the writer with a 20 per cent. solution of protargol, which corresponds to the disinfecting strength of a 2 per cent. solution of nitrate of silver. Cranmer's technique (*Archive für Gynäkologie*) was exactly followed. In 27 per cent. of the cases there was no secretion; in 52 per cent. the secretion disappeared in the second day, and in only 24 per cent. did the secretion last longer than one day. In 80 per cent. of the cases there was none or very little secretion, which disappeared in the second day.—*Centralblatt für Gynäkologie*, No. 30, 1899.

George R. Southwick, M.D.

PERFORATION OF THE UTERUS WITH A CURETTE.—Abortion at the end of the third month with retention of the placenta, a foul discharge and sepsis required curettement after six weeks of treatment. The uterus measured 16 cm., and the placenta was situated at the fundus on the right anterior wall. The uterine wall felt very thin through the abdomen. There was apparently an excentric atrophy of the uterine muscle, due to two previous abortions which ran a pathological course. In removing the foul placenta by a curettement of 8 minutes' duration the curette perforated the uterine wall with light pressure at the placental site. The patient cried out at the same time, and the assistant felt the end of the curette through the abdominal wall. The curette was very carefully withdrawn, the placenta had been removed and further interference stopped; not even an intra-uterine irrigation was given. The uterine cavity was packed with iodoform gauze, an abdominal bandage firmly applied, and an injection of ergotin was given to secure better contractions of the uterus. The uterine tampons were renewed; the pain ceased in a few days at the site of the perforation; the lochia and temperature became normal; the uterus involuted, and the patient recovered.—*Ibid.*

George R. Southwick, M.D.

THE THERAPEUTICS OF PUERPERAL FEVER. (Geuer.)—Ulcers about the perinæum and in the vagina are best treated by irrigation and powdering with iodoform or aristol; strong caustics are to be avoided. Ulcers on the cervix should be irrigated carefully to avoid washing infectious material into the uterine cavity. If the fever arises from the uterus, as in simple retention of the lochia, the cavity should be washed out. If endometritis is present he recommends frequent and thorough irrigation with $\frac{1}{2}$ per cent. to 1 per cent. lysol solution, and the use of ergot and ice-bags to prevent extension of the process to the peritonæum. He does not believe in curettement of the endometrium on account of the danger of perforation, and that the operation will cause the process to spread.

In parametritis, extending from a laceration of the cervix, he recommends first ice-bags. If pain and fever persist and resistance can be felt he recommends hot applications and early opening of any abscess formation.

Rest is the most important in pelvic peritonitis. The intestine is quieted by light opiates, and the ice-bag is recommended. The chief object is to limit the peritonitis, for if it spreads there is little hope of recovery, even by laparotomy.

Therapeutics is useless in general sepsis without local manifestation, and must be confined to building up the strength of the individual. In pyæmia, which

usually accompanies removal of the placenta, local interference is only permissible when there is a suspicion that portions of the placenta have been left behind. All manipulations which cause a chill are to be strictly avoided. Operations, such as total extirpation, etc., are useless, and to be condemned. The thorough use of ergot and the free use of alcohol are recommended. He has used with success hypodermic injections of creasote and oil of camphor in equal parts up to eight times a day with good results and without any disadvantage.—*Ibid.*

George R. Southwick, M.D.

IDIOTIA AMAUROTICA FAMILIARIS.—Cases of this disease were first described by Warren Toy in 1881; other observers have reported cases since 1881. But our knowledge of this disease was not systematized until Dr. B. Sachs, of New York, collected all the reported cases and symptoms, and investigated in the post-mortem room the anatomical changes associated with the disease, and thus gave us a complete picture of the disease under consideration.

Prof. Mohr said that his case is the thirty-fifth on record, and the fourth in which a post-mortem examination of the eye was made. The brain was examined by Prof. Schaffer and the eyes by Prof. Mohr. He gives the following summary:

1. Amaurotic family idiocy is a well-defined disease.
 2. Its chief characteristics are that the children are born normally, develop well bodily and mentally until they are a year old; after this they become stupid; the extremities become weak, sometimes rigid and at other times flexed; the reflexes are either normal or diminished or exaggerated; the acuity of vision is diminished.
 3. In each eye, in the region of the macula lutea, there is a typical red area which is diagnostic. Atrophy of the optic nerve follows, and usually the children die in their second year.
 4. This disease usually occurs in several members of the family.
 5. In the brain, especially in the cerebrum, cerebellum and pyramidal tracts, there are numerous small spaces; the brain-cells are wanting in some places, in others they are the seat of fatty degeneration and atrophy.
 6. The macula lutea is œdematous, and there is atrophy of the optic nerve.
- Prof. M. Mohr (*Gygyaszat*, March 19, 1899).

William Spencer, M.D.

TREATMENT OF DETACHED RETINA.—The phase through which the treatment of detachment of the retina is now passing. De Wecker decries the performance of operative treatment in detachment of the retina. He confines his radical form of therapy to subconjunctivæ injections, combined with Samelsohn's method, in cases of well-to-do patients, or the use of pills of bi-chloride of mercury among the poor. The form of serum which he injects consists of three and a half parts of gelatine in association with one hundred parts of a physiological salt solution. The explanation of the good results obtained by this method, he says, is offered by Raehlmann's theory, which assumes that detachment of the retina is caused by the large amount of fluid that is attracted to the vitreous humor which is surcharged with salt, this excess of salts being neutralized by the serum.—De Wecker, Paris (*La Clinique Ophthalmologique*).

William Spencer, M.D.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND
THERAPEUTICS.

CINERARIA MARITIMA AND CATARACTS.—*Cineraria maritima* seems to hold the attention of many enthusiasts who believe its local application has considerable power in curing cataracts. Others claim that its internal use is sufficient to produce the same effect and with less danger. It seems to have an affinity for abnormal tissue development affecting serous surfaces; it is supposed to cause softening and absorption of opaque structures. The efficacy of the application of this remedy locally and its internal use are not sufficiently settled yet, however, to warrant too enthusiastic commendation.—*Clinique*, July 15, 1899.

TREATMENT OF GASTRALGIA.—Dr. F. Cartier recommends chiefly one remedy in this affection, an actual neuralgia, and that is *bismuth*, 3x-6x; in case of non-success, one may have recourse to *nux vom.*, *zincum argentum*; but if *bismuth* does not succeed, then there is probably a gastritis mixed with the gastralgia.

F. Mortimer Lawrence, M.D.

FERRUM PICRICUM IN HYPERTROPHY OF THE PROSTATE.—Dr. D. Wright warmly recommends *ferrum picricum* 2x-3x in the disturbances caused by hypertrophy of the prostate. The drug will not reduce an enlarged prostate to the normal, but it will still do a great deal. It acts best, of course, in the early stages, *i.e.*, in the first twelve months after the appearance of the symptoms. The most prominent and distressing symptom, the rising at night to urinate, is immediately ameliorated. The secondary symptoms of stasis, as especially the hemorrhoids, the prolapse of the rectum, etc., are very favorably influenced. The residual urine is greatly diminished, in one case from three hundred to sixty grammes in two months. He thinks that if it be used early it is able to prevent the further progress of the disease. The disagreeable sensation in the neck of the bladder that these patients have is also ameliorated. Here he advises *bell. 1c.* in alternation with *ferrum picric.* Those cases where the prostate is greatly enlarged, with decided catarrh of the bladder, are less amenable to treatment. Regular irrigation of the bladder, with the remedies internally, still will do much. In the proper cases he excises a portion of the vas deferens.

F. Mortimer Lawrence, M.D.

CEANOTHUS FOR SPLENIC ENLARGEMENTS.—*Ceanothus* is a remedy used often with success for splenic enlargements when malaria is not a complicating cause. It may be indicated in simple leucocytosis when there is no formation of myelocytes, as in the true leukæmia. It would naturally be indicated in splenic involvement after typhoid fever. Prolonged anæmia is always an attendant symptom.—*Clinique*, Aug. 15, 1899.

KALAGUA IN TUBERCULOSIS.—Kalagua is another new remedy which, it is claimed, gives good results in the treatment of tuberculosis. It is said to be non-toxic and causes no deleterious effect upon the alimentary canal. Some special sanitarium experiments have given favorable results in desperate cases. It relieves the hectic fever, aids the expectoration and decreases the tuberculous infiltration. It ranks with ichthyol and guaiacol.—*Clinique*, Aug. 15, 1899.

F. Mortimer Lawrence, M.D.

TREATMENT OF SCURVY BY TINCTURE OF IODINE.—Dr. Martinov, of Novoladoga, Russia (an allopath), reports two remarkable cases of scorbutus cured by the internal use of tincture of iodine. The first had resisted the usual measures, and especially dieting, but commenced to improve as soon as he took four to five drops of the tincture in a glass of whiskey three times a day. He was wholly restored to health.

The second case was still more conclusive, and in a workman who suffered from very serious scorbutic lesions, as effusions of blood, multiple and gangrenous ulcers, some of which exposed the muscles and tendons. He was in an extreme state of exhaustion, exhaled a nauseating odor, complained of continual pain and diarrhoea, and one day he cast off the gums, in a slough, of his lower jaw, with all the under teeth. Under the influence of the tincture of iodine the subcutaneous hæmorrhages were rapidly absorbed, and his ulcers healed. The treatment being suspended after several days he was again seized with pains, new blackish ecchymotic spots appeared under the recent cicatrices, and even the granulations of the healing wounds began to disintegrate. The tincture of iodine was again given, and a definite and lasting cure resulted.—*L'Art Medical*, No. 7, 1899. These interesting cases should have been accompanied by a report on examination of the blood, to have made the diagnosis certain and satisfy a close observer. There are other states which resemble scurvy, as purpura hæmorrhagica, scorbutic anæmia and leukæmia. Iodine will cause many of these symptoms, and particularly the ecchymoses.

Frank H. Pritchard, M.D.

APOMORPHINE AND ITS USES.—Apomorphine though at times employed in vomiting has still other uses. In a case of incessant vomiting in a neurasthenic (female) patient it was of actual service. It may be used in nervous vomiting, in emesis gravidarum and in sea-sickness. Its pathogenesis renders it indicated in weakness with fainting seizures; extreme weariness, depression, headache, difficulty of occupying one's mind with anything; inclination to sudden fainting attacks. Further, in profuse sweating, for it causes great sweating.

In cardiac weakness with slow, weak and irregular pulse, an inclination to sudden seizures of fainting, threatening heart paralysis and collapse; paleness of the face. (A serious state pointing towards myocardial degeneration, either primary or secondary, as, for example, in chronic renal affections.) The first few attenuations are best used. Five drops of the first decimal dilution were added to sixty grammes of water; a teaspoonful every half hour to hour was given in this neurasthenic case.—*Leipziger Populäre Zeitschrift fuer Homœopathie*, Nos. 13-14, 1899. Seiffert—*Formulaire de Thérapeutique Positive* (1899), p. 36—recommends apomorphine in vomiting of cerebral origin; in croupous pneumonia with difficult expectoration, in alternation with phospho-

rus 6x every two hours. Also in chronic bronchial and pulmonary catarrhs, with difficult expectoration. Tartar emetic is very similar in its action. Tabacum is also analogous, but the whole human race is so saturated with this drug that this toxicologically interesting plant is not much used. This drug should be kept tightly stoppered, or oxidation will soon occur, and it turn greenish and later blackish. The muscular weakness from its action is alarming, there is headache, giddiness and a disposition to yawn, with free perspiration and great drowsiness with apathy. The pulse is very generally diminished in force and volume (H. C. Wood). An old and greenish preparation may give rise to alarming symptoms.

Frank H. Pritchard, M.D.

PETROSELINUM IN DYSURIA FROM PROSTATIC ENLARGEMENT.—Dr. ———, an anonymous correspondent of the *Leipziger Populäre Zeitschrift fuer Homœopathie*, Nos. 15-16, 1899, was consulted by a planter of well along in life with a hypertrophic prostate, who complained of frequent urging to urinate, every half to three-quarters of an hour, with burning pains in the bladder and urethra. No albuminuria. Canth., sulph., cann. ind. were without result, and on account of the suddenness of the urging to urinate, with violent and burning pains before and during urination, petroselinum 4x was given, three drops in water every hour. In a few days his pains had disappeared and the tenesmus had decreased in severity. His prostatic trouble remained uninfluenced. (Sieffert, in all his indications for petroselinum, speaks of the *urgent suddenness of the desire to urinate* as characteristic.) It has an elective action upon the urinary tract affecting the mucous membrane; there is frequent desire to urinate, caused by a tickling sensation behind the navicular fossa. The urethral orifice is agglutinated by mucus; a milky discharge. In blenorrhœa there is a sudden desire to urinate which is pressing. In cystitis there is a violent urging to micturate which is felt suddenly. In children with spasm of the bladder the tenesmus is experienced *suddenly*.

Frank H. Pritchard, M.D.

MEDICAL TREATMENT OF APPENDICITIS.—Dr. P. Jousset, of Paris, in a discussion at a recent meeting of the French Homœopathic Association on appendicitis stated his treatment to be:

Belladonna.—This remedy corresponds to the pain, the vomiting, the constipation and the grave paralysis of the intestine. The first decimal trituration fifty centigrammes, or even one gramme in two hundred grammes of water. One teaspoonful every one to two hours.

Bryonia.—This drug is second in importance. It may be alternated with belladonna.

Colocynthis.—One drop of the tincture to three teaspoonfuls of water is indicated in the excessive pains.

Finally, if called late in the disease and if grave symptoms of peritonitis and collapse, arsenicum and carbo veg. will be of great service. In case that the constipation resists both bell. and bryonia, calomel 1x, ten centigrammes every three hours, may be administered. It is a convenient laxative. The usual purgatives and even injections are generally badly tolerated.—*Revue Homœopathique Française*, No. 17, 1899. (I have seen good results from hyoscyamin diurnules in controlling the pain. It does not mask the symptoms like opium and its compounds nor confuse the patient's mind.)

Frank H. Pritchard, M.D.

KALI BICHROMICUM IN TONSILLITIS AND DIPHTHERIA.—Dr. T. Ord, in a critical investigation of kali bichromicum, recommends it in catarrhal inflammation with tenacious mucus which it is difficult to detach, and sore throat, with swelling and redness, and inclination to rapid formation of ulcers on the tonsils and uvula.

Tonsillitis which may be follicular and at times when pseudo-membranes form on the tonsils, soft palate, and in the fauces. They have a pearly appearance, are fibrinous and very difficult to detach. (Merc. biniod. is characterized by similarly colored but easily detachable and more circumscribed membranes.) There is often earache; sharp pains shoot into the head, ears or back of the neck. The parotid and submaxillary glands are swollen. Swollen tonsils and deafness in children and adults; there is indolent and slight inflammation, the muscles are flabby, there is a rotten taste in the mouth, thickening of the mucous membrane of the nose, with scabby nostrils.

In diphtheria this remedy is one of the most effective with tenaciously adherent exudates, ulcers, fetor, slight pain, but great depression. The tongue is yellowish-brown and furred; there is an inclination for the disease to extend to the nose or larynx, with increased redness of the surrounding mucous membranes. — *Zeitschrift des Berliner Vereines Homöopathischer Aerzte*, Bd. xviii., Heft 11, 1899. (I have found it indicated also by the adherent and pearly white exudate and a yellowish-coated and furred tongue like that of hydrastis.)

Frank H. Pritchard, M.D.

LOBELIA PURPURESCENS.—Dr. Withe presents the following as characteristic of this remedy:

Head.—Depression and confusion like that produced by the snake-poisons; nauseating headache, with vertigo, especially over the eyebrows.

Eyes.—Cannot keep the eyes open; almost spasmodic closure of the eyelids.

Mouth.—Viscid mucus in the mouth; the tongue white and paralyzed.

Heart.—Paralyzed; the heart-beat almost imperceptible.

Chest.—Sensation of paralysis of the lungs; superficial respiration.

Lungs.—Paralyzed, slow respiration, which almost completely ceases; profound prostration of all the vital forces and of the nervous system; chills without shaking. In consequence of the respiratory paralysis, the organism fills with carbonic acid, and vomiting and coma supervene. This drug, therefore, acts in serious typhoid states like baptisia. It combats the nervous prostration of the grippe, and appears to destroy the poison in this disease as baptisia overcomes that of typhoid.—*Revue Homéopathique Belge*, No. 12.

APIS IN ACUTE NEPHRITIS.—An anonymous correspondent of the *Leipziger Populäre Zeitschrift fuer Homöopathie*, Nos. 15–16, 1899, administered apis 3x with happy results in a servant girl of eighteen years, who was affected with a greatly swollen face, her eyes being so puffed that she could scarcely see, the skin being tense and pale in color and pitting on pressure. Decided albuminuria. For some weeks her body had been slowly swelling, yet she had worked until she was no longer able. Her heart's action was rapid and strong, and her feet and abdomen also greatly swollen. The remedy was prescribed in a dose of three drops every two hours, with rest in bed and a milk diet. Within four days the swelling had greatly decreased, so that in eight days both the dropsy and albuminuria had entirely disappeared. (Apocynum is often a good remedy to alternate with apis in such cases.)

Frank H. Pritchard, M.D.

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SOME POINTS CONNECTED WITH THE DIAGNOSIS OF DISEASES OF THE KIDNEYS.

BY CLARENCE BARTLETT, M.D., PHILADELPHIA, PA.

(Read before the Homœopathic Medical Society, State of Penna., Phila., Sept. 27, 1899.)

IN the clinical study of diseases of most of the viscera an investigation of the manner in which the suspected organs perform their functions constitutes a very important part of the examination. In the study of renal diseases, however, the many positively known facts, each bearing a positive significance, have led physicians to ignore the study of the kidneys as organs possessed of a function or functions, while paying almost exclusive attention to the well-attested symptoms, albuminuria, tube-casts, urea percentage, etc. Each of these has a clinical value which all of us must appreciate, but their discovery does not by any means decide the condition of the organs under study. Their true value is to be estimated only by studying them in conjunction with the history of the case and the present status of symptoms and physical signs. Practical and theoretical knowledge is, of course, increasing. There was a time when the presence of albuminuria was regarded as a *sine qua non* for the diagnosis of the class of cases generically known as Bright's diseases. While by no means wishing to ignore the diagnostic value of this symptom, I must say that a failure to estimate it at its proper value is responsible for very many erroneous opinions. Especially does this remark apply

to chronic interstitial nephritis, also known as gouty, contracted or granular kidney. In this disease albuminuria is rarely prominent, and is very frequently absent over long periods of time. Hence, even when present, it is liable to escape detection. If, however, the physician bears in mind the clinical history of chronic interstitial nephritis, and studies the kidneys as organs possessed of an excretory function eliminating a definite quantity of urine of specific gravity and composition approximating the physiological standard within certain well-known limits, he will make but few diagnostic mistakes. It is now universally recognized that interstitial nephritis is associated with certain cardio-vascular phenomena, namely, thickening of the arterial coats, hypertrophy of the left ventricle, and increased arterial tension. These phenomena, of themselves, are all sufficient to establish the diagnosis were no other data available. Fortunately, we need not depend upon them alone for an opinion. Routine examination may lead to noting "Urinary examination negative in its results." Systematic examination will demonstrate increased quantity of urine of low specific gravity, with marked reduction of phosphoric acid elimination. One recent writer—Laidlaw, of New York—has taken the position that deficient phosphoric acid elimination is "the" symptom, the existence of which must be determined before a diagnosis can be made, and the general consensus of opinion confirms him in the position he has taken respecting the value of this symptom. Polyuria is generally recognized as one of the early symptoms of the disease; and, indeed, it has a positive value, especially when occurring in persons at or beyond middle age, and when the polyuria is especially marked at night. Mitchell, of Chicago, directed attention to this point several years ago, stating that a persistent increase of the night's urine over that of the day was to be regarded as strong presumptive evidence of unsound kidneys. The same writer antedated many authorities in attaching great clinical importance to deficient phosphoric acid elimination.

It is universally conceded that the most important excrementitious component of the urine is urea, and, as a result, all of us have placed great value on the accurate estimate of the quantity of urea excreted. This is all very well as far as it goes; but it does not go far enough. Healthy individuals

taking a fixed quantity of mixed food should, if leading a moderately active life, eliminate a definite quantity of urea, variously estimated as from 400 to 500 grains daily. It is to be observed in this connection that the character and quantity of food taken and the habits of the individual affect the urea percentage. Again, though the kidneys be perfectly sound, urea percentage may be decidedly altered because of general malnutrition. Hence the percentage of urea eliminated must not of itself be regarded as the index of the state of health of the kidneys. Still further, the experimental investigations of John Rose Bradford have shown that when portions of the kidneys amounting to not more than two-thirds of the entire structure of these glands are destroyed, the animal still preserves its normal standard of nutrition, and may live on indefinitely in apparently good health; but an increased quantity of urine, rich in urea, is eliminated. But if the destruction of tissue includes more than the amount above specified, the animal emaciates rapidly, the quantity of urine diminishes, while the urea elimination is enormously increased; and, notwithstanding the free excretion of urea, examination of the blood and muscles shows a retention of that substance in these tissues far in excess of the normal standard.

It is not an easy matter as yet to give these investigations of Bradford their proper place in clinical medicine. The polyuria succeeding the destruction of two-thirds or less of the entire renal structure seems to demonstrate that the same symptom when occurring in conjunction with chronic interstitial nephritis is due to the destruction of kidney substance, and not, as heretofore maintained by many authorities, to the increased vascular pressure so commonly attendant upon this disease. The explanation to be attached to increase of urea after extensive kidney extirpation is not so easy. It is evident, of course, that there is increased urea production in the tissues, especially in the muscles; but "Why does this occur" is a most proper question. Bradford believes—and no better explanation, I take it, can be given in the present state of medical knowledge—that the kidneys may also exert a function as organs of internal secretion, the destruction of which causes important tissue changes throughout the entire body.

Reference to urea excretion naturally suggests the subject of

uræmia. As to what constitutes uræmia is a question more easily asked than answered. As originated, the term was intended, of course, to designate the poisoning of the blood by retention of urea which should be eliminated. An extensive hospital experience with the terminal stages of renal diseases shows that the majority at least of cases of uræmia, so-called, are not examples of uræmia at all, but simply examples of modes of death from renal disorder. The great doubt surrounding the nature of so-called uræmia is well shown by the definition of that condition given by Bradford (*Allbutt's Practice*, vol. iv., p. 324): "A group of symptoms arising during the course of many renal diseases; always grave, not infrequently fatal, and dependent mainly, but not entirely, upon derangement of the functions of the nervous system." It will be observed that this definition expresses no opinion as to the merits of the mechanical and toxæmic theories advanced for the explanation of this condition, and it well illustrates current uncertainty on the subject. A former coroner's physician, H. F. Formad, after an autopsy on one of my patients who died with rapidly-appearing coma and with well-advanced kidney disease as the only pathological condition, remarked that death did not result from uræmia, although dependent upon kidney disease. His successor, Dr. Henry Cattell, in a very similar case, stated that uræmia was the cause of death, basing his diagnosis on the state of the kidneys. In reply to my question as to what constituted uræmia, Dr. Cattell said that uræmia was a term that covered a multitude of sins and ignorance; that it was a convenient term to use to designate the cause of the fatal termination of renal diseases. In both patients the flow of urine was somewhat diminished; neither had albuminuria; and both excreted sufficient urea to lead one to believe that there was sufficient of that substance excreted to make poisoning by it out of the question.

In hospital practice it is a common experience to receive patients taken with coma in the midst of apparently good health. The majority of these exhibit the characteristic urinary changes of interstitial nephritis; others have merely deficient urination with or without high arterial tension and thickening of the radial arteries' casts; and nearly all of those who die are discovered to have well-advanced cirrhosis of the

kidneys and cardiac hypertrophy. For want of a better term we are obliged to say that they die of uræmia, basing the diagnosis on the symptoms rather than upon any positive evidence of uræmic poisoning.

The evidence at our disposal tends to show that the phenomena of so-called uræmia are of toxæmic rather than mechanical origin. In view of the fact that the symptoms accompanying this condition may consist of coma, delirium, paralysis, convulsion, dyspnœa, or gastro-intestinal disturbance, it is fair to presume that the poison producing the disturbance cannot be the same in every case. All poisons introduced into the body from without exhibit a well-defined symptomatology subject to exceptions within circumscribed limits, due to the idiosyncrasies of the patient. In no instance, however, do we observe the great symptomatic variations described as characteristic of the so-called uræmia in its various types. That the condition is one of blood-poisoning we now assume. To persist in speaking of it as uræmia tends to clinical and pathological inaccuracy. The term "renal toxæmia" should be substituted as suggesting the organ at fault, while not binding us to assume any special poison as producing the symptoms.

Cases of renal toxæmia vary greatly in their clinical course. The division into acute (including the fulminating) and chronic types, is well known. The so-called latent uræmia is less frequently observed, though none the less real. It occurs usually in conjunction with calculous suppression. The symptoms are remarkable for their mildness; indeed they do not resemble in the least the ordinary picture of renal toxæmia. Although no urine may be passed for ten or twelve days, the patient complains of but little other than weakness and drowsiness; the tongue is dry and brown; and the pupils are contracted. There may be some slight twitching of muscles. The temperature is subnormal.

Attempts have been made to explain the cerebral symptoms of renal toxæmia by claiming the existence of œdema or anæmia of the brain, general or localized according to the extent of the symptoms. Such an explanation is theoretical in the extreme, as it has always been impossible in the cases in which these changes have been found to determine whether they were the cause or the result of the convulsive phenomena. My case of

Jacksonian epilepsy reported years ago exhibited no local oedema, while there existed widespread atheromatous changes in the cerebral blood-vessels, the basilar artery virtually being as brittle as a pipe-stem. Dr. Goodno's examination of the motor portion of the cortex shows degenerative changes. It is claimed that a systemic poison is incapable of producing localized effects. In most instances this is true; but we have remarkable examples of poisons having a selective affinity for a locality, *e.g.*, lead, arsenic, and alcohol in the production of neuritis of peculiar distribution. It is fair to presume that the active poison of renal toxæmia may likewise exert a selective action on this or that portion of the brain.

The orthodox convulsion of renal toxæmia consists of tonic and clonic spasms; in other words it is of the epileptiform type. Too much reliance must not be paid to this, for in two instances I have seen hysteroid convulsions, in both of which the diagnosis was confirmed by autopsy. It is more than probable that the motor symptoms were indirect results of the toxæmia, the patients in all likelihood being highly neurotic.

Incidental reference to albuminuria was made in the opening words of this paper. The value of this symptom may be stated briefly as follows: The presence of albuminuria indicates only that a pathological condition of some kind is present; its absence must be regarded as a negative sign, and possessed of but little diagnostic value. If present, it may be due to the accidental contamination of the urine with an albuminous fluid, or it may be a true albuminuria. If the latter, it may or may not be symptomatic of organic kidney disease. As a non-renal symptom, it may be purely mechanical, arising from congestion due to cardiac or pulmonary disease; hæmatogenous as the result of anæmia, toxæmia, or fever; purely functional, which in the present state of medical knowledge may be taken to mean almost anything. In each and every case of albuminuria the significance of the symptom can only be obtained by studying it in conjunction with all the other signs and symptoms, and the life history of the patient. It is unfortunate that this opinion of albuminuria is not more prevalent than it is, for much harm is now done on the one hand by regarding an ephemeral albuminuria accidentally discovered, *e.g.*, in the course of an examination for life-insurance, as a serious matter;

and on the other hand serious renal disease fails of recognition because albuminuria happens to be absent.

As regards the absence of albuminuria in the course of chronic interstitial nephritis, it is astonishing to note its frequency. Time after time have I seen patient's die with advanced kidney disease, with this symptom noteworthy for its absence.

The presence of tube-casts, especially of the granular and epithelial varieties, is to be regarded as pointing unquestionably to the presence of renal disease. The hyaline variety may be present in functional disturbances, and, it is claimed, even in healthy persons. While casts are liable to appear especially in albuminous urines, the fact that a urine is non-albuminous should not lead to the neglect of a microscopic examination for casts. At one time it was thought that the character of the casts present afforded a sure index of the pathological condition of the kidneys. This is a mistake. On this subject Lionel Beale remarks: "Dr. Basham thinks he can judge of the stage of Bright's disease by the character of the urinary sediment. I wish I could agree with him in this conclusion. The more carefully the matter is investigated, the more convinced am I that it is unsafe in many cases to attempt to draw inferences as to the stage of the disease from the character of the urinary sediment only. Nothing but a very careful consideration of every point will enable us to arrive at a general conclusion concerning the state of the disease." Grainger Stewart, referring to the diagnostic value of casts, says: "Casts are of undoubted value in establishing the existence of Bright's disease, considered generically, but they afford comparatively little assistance in the differential diagnosis of the different forms. Any form of tube-cast may occur in any form of the disease, and at almost any stage. Indeed all the leading varieties may occur simultaneously in one case." Tirard, commenting on the above, remarks that "notwithstanding all the above reservations, renal casts often afford the best and clearest indications of the nature of the changes that are affecting some part of the gland tissue, even though they do not and cannot give any clue to the extent to which the whole of the kidney is affected."

There is a class of neurasthenic cases the most remarkable feature of which is the general malnutrition. Several such

under my care never excreted more than sixteen ounces of urine daily, notwithstanding very free water drinking and high colon enemata. The rest treatment availed nothing. Fresh air and good food constituted the best treatment. Repeated examinations by experts failed to discover any other evidence of kidney disease. Undoubtedly the anuria was the result of defective metabolism.

Such cases must not be regarded as allied to the renal inadequacy of Sir Andrew Clark. This condition was described by that eminent clinician as one in which there was no alteration in the structure of the kidneys, and yet those organs are unable to produce a healthy urine, which fluid is generally found to be deficient in solids, especially in urea. The subjects of the disease—if disease it may be called—exhibit a curious inability to repair “damage done to them by either accident or disease; not only do they repair damage slowly, but they are peculiarly vulnerable, and there is an uncertainty as to the results of surgical operations performed upon them.” Viewed by the light of the present day, Clark’s renal inadequacy is in all probability but the initial stage of an interstitial nephritis.

The cardio-vascular phenomena of interstitial nephritis afford, as already stated, a most valuable means of diagnosing the disease. Time after time have I seen high arterial tension, thickened radial arteries and left ventricular hypertrophy lead the way to the correct appreciation of the renal condition. These phenomena are also of importance in relation to the production of many cases of apoplexy and cardiac failure. While the high arterial tension is often a source of increased cardiac labor and endangers the integrity of the degenerated blood-vessels, its presence must not be regarded as an unmixed evil, for cases of interstitial nephritis which do not have this high tension, according to Broadbent, should be given an unfavorable prognosis. I have observed that the majority of patients with thickened arteries and low vascular pressure are poor subjects for the major surgical operations, the majority of them dying from cardiac asthenia.

Interstitial nephritis is noteworthy for the great variety of nervous phenomena, the prominence of which may take attention from the kidneys, as the *fons et origo mali*. Some of these are toxæmic; others are due to the general fibrosis which is

nearly always associated; still others to the increased vascular pressure and circulatory disturbances. The following case is one which has always been a puzzle to me: Mr. W. consulted me May 31, 1891, at the suggestion of Dr. R. T. Wiltbank. He gave a history of albuminuria existing for years. His present trouble began early in the spring, when he found himself unable to partake of any food without vomiting. The physician who was called in prescribed bismuth and morphia, which did no good. He lay in bed for a month or two, and then he got about and resumed the practice of his profession. During the winter he started in with a rheumatic trouble in the arms and legs. His recovery from this trouble he attributed to wearing sulphur in his shoes. Then there came on a numb feeling, which extended up the legs to the knees, and likewise invaded the arms and hands. That in the latter locality became so marked as to make accurate movements of the fingers impossible. At the time of his visit he still complained of this stomach trouble. Nearly every morning he vomited nearly pure mucus. He was decidedly dyspnoëic during conversation, this symptom having appeared about five or six weeks before. He was subject to a severe tremor, which came on under any excitement, but this I never had the opportunity of seeing. He had not had any headache of late, although for a number of years he suffered from neuralgia. The movements of the hands were decidedly inco-ordinate. He could not perform such simple movements as buttoning his clothes, and he could walk only with the aid of a cane, and that with difficulty. There was static ataxia, with eyes closed. The heart-sounds were normal but for an accentuation of the aortic second sound. Pulse tension was increased. His face was pale and waxy. His urine gave a specific gravity of 1010; albumin one-tenth of one per cent. by Esbach's albuminometer. The dynamometer grasp of the right hand was 35 degrees; the left also 35. He was right-handed. The treatment consisted of as nearly absolute rest as possible, a strictly vegetable and milk diet, and glonoin 1, one drop four times daily, and nux vomica, phosphorus and arsenic, according to indications from time to time. Improvement though slow was steady. The ataxic gait had nearly disappeared by October 1, when the patient returned to his business. He continued perform-

ing most arduous duties for three years without any return of his symptoms, although the urinary condition remained as at first. After an exciting political campaign the vomiting returned, but was relieved by lavage and rest in bed and remedies. In the midst of improvement he was seized with right-sided hemiplegia, and died within a few days. No autopsy was permitted. I have always believed that the paraplegia in this case was dependent upon circulatory disturbances. Certainly there could have been no organic changes in the spinal cord. Meigs, in his interesting work on the origin of disease, referring to the general fibrosis associated with interstitial nephritis, says that many times he has found this condition invading the spinal cord when there were no symptoms during life to suggest involvement of this organ. I have often thought that many of the paraplegias—ataxic and spastic—observed in patients past middle life were but part of the constitutional condition attendant upon gouty nephritis.

I cannot close without a few words relating to prognosis. Interstitial nephritis is universally recognized as an incurable disease. It must be conceded, however, that with due care its victims may live for years in comparative comfort. In 1882 a case of this disease, with obstinate epistaxis and insomnia, was referred to me for an opinion. I was under the belief that he had long since been dead when he called on me two years ago, at the suggestion of Dr. J. M. Gerhart, for further examination. I have seen other cases in which the albuminuria and polyuria were discovered years back, and who continue in a fair state of health. It must be remembered that the kidneys, like other organs of the body, are capable of performing their functions to a degree in excess of what the system requires; hence they may be extensively diseased without producing serious symptoms, or indeed any symptoms. Failure to recognize this wise provision of nature has led to the framing of unfavorable prognoses not confirmed by the subsequent progress of the cases.

GLONCIN IN ABDOMINAL PULSATIONS.—Dr. Willoughby Wade, in those hysteric or neurasthenic women who suffer from distressing throbbing of the aorta, which is noticed as a "beating or pulsating sensation" in the abdomen, has obtained excellent results with very small doses of trinitrine. Three decimilligrammes administered in the evening on retiring; this represents about five drops of the third decimal dilution.—*L'Art Medical*, No. 7, 1899.

THE "STOMACH MEDICINES" OF RADEMACHER.

Translated from the Original and Condensed,

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NOTE.—The attention of the translator was first directed to Rademacher by reading the interesting little books on *The Liver* and *The Spleen*, by Dr. J. C. Burnett. In Rademacher's book, *Rechtfertigung*, etc., he found, as did Dr. Burnett, a mine of therapeutic suggestion. Except for the sections on the liver and the spleen referred to, no English translation of Rademacher exists, for which reason the following extract is published. The translator makes no effort to modernize Rademacher's conception of pathology or diagnosis, believing that the observations of an honest man have a worth of their own, irrespective of their relation to prevailing methods of thought.

During the past three years the translator has had frequent opportunities to test the usefulness of calcium chloride, iodine and *carduus Mariæ* in trying cases, and can endorse Rademacher's account of the remarkably prompt and effective action of the medicines.

STOMACH MEDICINES.

Primary disease of the stomach is difficult to detect, because the stomach is frequently made to bear the ills of other organs. The various pains known as *stomach-ache* are usually sympathetic, and are cured, not by stomach remedies, but by medicines directed to the organ primarily diseased.

Lack of appetite in convalescence is not a disorder of the stomach, but merely a sign that the original disease is not entirely cured. Such symptoms as *heartburn*, *hiccough* and *regurgitation* are usually dependent upon disease of the liver, spleen or portal system. Diseases expressing themselves by *vomiting*, especially with excessive acidity, are apt to be primary stomach diseases. It is true that vomiting is sometimes secondary, as the vomiting of pregnancy, of calculus or *volvulus*; but, compared with other gastric symptoms, the persistent rejection of all food and drink is the most reliable sign of primary stomach disease.

Whether primary or secondary, vomiting is a troublesome symptom and should be checked, if possible. Well-known

remedies for this purpose are *bismuth subnitrate* and *potassium and sodium acetate*. It is important to determine if there is excessive acidity of the gastric juice. If it is too acid, I know of nothing so promptly effective as a mixture of 2 drams of *carbonate of ammonia* and 20 grains of gum tragacanth in 8 ounces of water; teaspoonful every hour. With this medicine I have relieved many patients of chronic vomiting, even those who had vainly tried other remedies. It may be the carbonic-acid gas that does the work, for *sparkling champagne* will accomplish the same purpose.

Iodine is one of the most reliable remedies for vomiting. Of a mixture of 30 drops of the tincture and 20 grains gum tragacanth in 8 ounces of water, give a teaspoonful every hour. The mixture is at first dark, but becomes light. Iodine often relieves stomach pain as quickly as opium.

The first case in which I used iodine as a stomach remedy was one of scirrhus of the stomach in an old brandy-toper who consulted me because liquor "did him no more good." There was persistent vomiting and a ceaseless pain in the stomach. After the failure of well-tried remedies, I concluded that it was a case of scirrhus of the stomach, though no tumor could be made out. Compelled by my duty to give my patient every chance of relief, rather than with any expectation of cure, I gave him 5-drop doses of tincture of iodine in barley-water, five times daily. The action was so remarkable that I was puzzled and doubted the correctness of my diagnosis. The vomiting ceased and the torturing pain was appreciably relieved. However, it was a suspicious circumstance that this man, formerly so strong, and after such marked relief, had no desire to leave his bed, and that his pulse remained rapid like that of a consumptive. After a week's time the pain and vomiting gradually returned, and the iodine failed to relieve.

In the treatment of incurable diseases one learns the true power of remedies. A medicine that will affect favorably an incurable disease, if only for a short time, may be relied upon to cure curable diseases of the same organ. Thus I found in iodine a valuable remedy for stomach diseases characterized by pain or vomiting. For scirrhus of the stomach I know no cure.

Calcium Chloride (Liquor Calcariae Muriati).—I know not whether other physicians use this remedy. Its beneficial local action on old ulcers and other external diseases led me to be-

lieve that it might be of service in relieving obstinate vomiting. In describing the ruling abdominal disorder of 1828, which was cured by bitter-almond water, I have already mentioned two cases in which the disease began with vomiting and stupor. One of these patients was in a desperate state. The face was drawn, as in a dying man. The body was cold, the pulse scarcely perceptible. The patient vomited and retched violently, without cessation, not only when drink was taken but without apparent cause. Thin stools oozed from the anus without the patient knowing it. I had given this man all the medicines, both external and internal, which I had hitherto used to relieve vomiting, but in vain. He lay for twenty-four hours in practically the same condition, except that the diarrhoea ceased, and the body did not seem quite so cold. From the continual retching the præcordium had become very painful. The gall-ducts were likewise implicated; for, on the third day, jaundice appeared.

I now resorted to calcium chloride, making a solution of 1 part to 2 parts distilled water. Of this solution I gave 15 drops in one-half cup of water. The result was most satisfactory. The retching and vomiting ceased, the skin became warm and the pulse more perceptible. Full consciousness returned, and the disease ran a mild course to recovery.

The second case was not so extreme, but of longer duration. During six months a young woman had been vomiting food about half an hour after eating. As the rejected matter had a sour odor, I gave her ammonium carbonate. The sourness disappeared, but the vomiting persisted. Next I gave iodine, without good results. I now used 15 drops of the liquor calcariae muriati five times daily, and the six months' vomiting was soon cured.

The third patient was a poor servant-girl who had become too weak to work, having vomited all food and drink for two months. The calcium chloride cured. In this case it was difficult to determine whether the vomiting was of gastric or other origin. From the jaundice and pain in the præcordium, it seemed as if the liver might be the diseased organ.

The fourth patient was a young woman who had suffered from pain in the left hypochondrium and distressing vomiting of blood. The calcium chloride cured.

From this time until 1836 the calcium chloride served me as

a reliable stomach remedy, not only for vomiting, but for gastric pain, bloating, eructations, etc., which were uninfluenced by sodium or potassium acetate, bismuth, iodine or carbonic-acid gas. He who wishes to classify these conditions under their academic titles may do so. I do not do it, because I know that it is of little service in the cure.

Hæmatemesis is rarely fatal, except when it is the closing scene of cancer. It is usually a result of chronic disease of the spleen; less frequently of the liver. People who have suffered for a long time with pains in the left hypochondrium are apt to vomit blood, after which the pain disappears. The hæmorrhage is sometimes beneficial, and should not be checked too soon by astringents; but here one must exercise common sense, as there is an element of danger in all hæmorrhages. I am in the habit of telling patients who suffer from this persistent pain in the region of the spleen that sooner or later they would vomit blood, in which event they need not be frightened, as it would be beneficial. With this warning the patient is less apt to be frightened by the appearance of the blood; and in the treatment of all hæmorrhages a calm and assured mind is a real healing agent. In the treatment of the attack it is of the utmost importance to quiet the fears of the patient.

In the treatment of hæmatemesis it is best to use a remedy that acts upon the epigastric region without irritating the stomach and interfering with the healing of the lesion. For sixteen years I have used a decoction of the seeds of *carduus Maricæ* with more satisfaction than any other remedy. I formerly gave opium in small doses. Opium is a good remedy, but, in some people, produces an array of symptoms similar to those seen in severe hæmorrhage, and might aggravate the condition.

Blood-letting is useless. Mild laxative medicines are serviceable in clearing the intestinal canal of the blood which, from its foul odor when passed, must undergo putrefaction within the body. A mild catharsis prevents the fever that is often observed after hæmorrhage of the stomach. In elderly people, and those who are very weak, no laxatives should be given.

It is probable that many small hæmorrhages of the stomach escape notice because there is no vomiting, and that it is in this manner that obscure abdominal complaints are sometimes suddenly relieved or cured.

A CONTRIBUTION TO THE SURGERY OF THE GALL-BLADDER AND BILE-DUCTS.

BY WILLIAM B. VAN LENNEP, A.M., M.D., PHILADELPHIA, PA.

(Read before the Homœopathic Medical Society, State of Penna., Phila., Sept., 1899.)

I PROPOSE to reverse the usual order of a medical or surgical essay and preface my remarks by narrating a few typical histories, selected from forty-odd operative cases that have come under my care. They are intended to illustrate the morbid conditions amenable to surgical intervention rather than medicinal or expectant treatment, and as such will serve for a text in a brief discussion of the surgery of the gall-bladder and bile-ducts.

CASE I.—Female; married; 48 years old; patient of Dr. Hughes, of Kennett Square.

History.—She suffered from persistent pain and tenderness in the region of the gall-bladder, where there was a vague sense of tumefaction, which was hard to distinguish from the muscular rigidity present. There had been no acute exacerbations or coincident jaundice, but she was the subject of a relapsing appendicitis, and some of the recurring attacks of pain might have been hepatic instead of appendicular colic.

Operation.—Through Langenbuch's incision an unprotected appendix full of pus was removed, and, on enlarging the wound to the rib-border, the gall-bladder was found packed full of calculi, and so contracted that it could not be drawn up into the wound. The ducts were empty. A hæmostat was applied to the gall-bladder to locate it subsequently, a protective gauze pack introduced, and the wound partly sutured.

Persistent vomiting followed the operation until the clip was removed, when it ceased. Free oozing of blood without apparent cause was also a troublesome symptom for several days. The opening of the gall-bladder was postponed for nearly two weeks, when seventy-four calculi were extracted; and, as the ducts were found to be patulous, this wound was closed and the abdominal opening sutured around a small drain. There was no subsequent leakage of bile.

Diagnosis.—Chronic, calculous cholecystitis, associated with relapsing appendicitis.

CASE II.—Female; married; 42 years old; patient of Dr. Conover's, of Fort Washington.

History.—She was suddenly taken, two days previously, with acute pain below the right rib-border, associated with exquisite tenderness, rapid pulse, temperature rise and abdominal distention, which was not relieved by enemata or purgatives. She was moderately jaundiced.

Operation.—A vertical incision showed a tense, fluctuating gall-bladder partially buried in old and recent adhesions, outside of which was a quantity of serous effusion. After a thorough toilet and isolation, the gall bladder was surrounded by an iodoform gauze pack. Four days later some eight to ten ounces of dark, thin fluid and pus were evacuated, and three gall-stones teased out of the cystic duct. The mural and visceral wounds were sutured around a drain, and the fistula rapidly healed.

Diagnosis.—Empyema of the gall-bladder from cystic duct obstruction; ancient and recent fibrinous, followed by serous peritonitis.

CASE III.—Female; multipara; 47 years old; treated in the surgical wards of Hahnemann Hospital.

History.—For some time the patient had noticed a tumor on the right side of the abdomen, on a level with and extending a little above the umbilicus. This tumor was constantly tender, and gradually increased in size during successive attacks of colic and digestive derangement without jaundice. Thirty-six hours before admission an attack came on, more severe than any previous one, associated with temperature and pulse rise, constipation, vomiting and distention. The patient was sent to the hospital with the diagnosis of an appendiceal abscess and consequent peritonitis. The symptoms certainly seemed to warrant the conclusion arrived at, as such an abscess could readily result from a leaking, upturned appendix. Fortunately a careful study, with the class during clinic, of the history, the clean-cut tumor and its location, together with the recognition under ether of its continuity with the rib-border rather than the caput coli, enabled us to make out the condition. The beginning peritonitis, presumably septic, called however for immediate intervention in any case.

Operation.—A vertical incision was made over the most prominent part of the tumor, which proved to be the gall-bladder imbedded in a mass of grayish-yellow, fibrino-purulent exudate, together with some old and firm adhesions. The abdomen contained a quantity of turbid fluid, the diffuse infection evidently coming from the unprotected, distal end of the sac. With the aid of mops, after a thorough peritoneal toilet, the gall-bladder was drawn out of the wound and fully one-half of it, which was gangrenous, resected. A pint or more of fetid pus and bile-stained mucus was evacuated, together with several hundred gall-stones, some of which were impacted in the cystic duct. The common duct was free. Bile began to discharge from the opening at the end of four days, and the wound healed promptly, partly by granulation and partly after a secondary suture.

Diagnosis.—Gangrenous cholecystitis of calculous origin; sero-purulent, fibrino-purulent and ancient fibrino-plastic peritonitis.

CASE IV.—Female; 43 years old; patient of Dr. Webster's, of Media.

History.—She had suffered for some time from recurring appendicitis, the attacks increasing in frequency and severity. Below the rib-border was a tumor which had been diagnosed as movable kidney. It slipped back into the loin just as the kidney does, and pressure produced the same sickening sensation. Its shape, the evident fluctuation and its continuity with the liver, however, decided us that we had a distended gall-bladder to deal with.

Operation.—The diseased appendix was removed through an incision in the right semilunar line, and the large, tense gall-bladder drawn into the upper angle of the wound and held in place by a protective pack, the lower portion being sutured. No calculi could be felt in the ducts. A week later about a pint of bile-stained mucus was evacuated. Fearing a cicatricial obstruction, as the probe would not go through the cystic duct, I sutured the mucous membrane to the skin, expecting a mucous fistula to result. A few days later bile began to discharge freely from the opening. The fistula ultimately healed with the aid of the actual cautery, and, while the gall-bladder swelled up and became tender some two years later, this disap-

peared without any special treatment. The attachment of the gall-bladder in the abdominal wound will give easy access to it in case of troublesome recurrence.

Diagnosis.—Hydrops of the gall-bladder from duct catarrh.

CASE V.—Male; 60 years old; seen with Dr. Pratt, of Coatesville, and Dr. W. C. Goodno, the medical consultant.

History.—For years he had suffered from recurring attacks of gall-stone colic associated with jaundice and the characteristic stools and urine. The overshadowing symptoms, at least early in the case, must have been the typical chill, fever and sweat, for he had been treated by previous attendants for malaria with large doses of quinine, etc.

Operation was undertaken as the sweat subsided after a febrile rise to nearly 106°. There was rigidity and tenderness below and inside the rib-border, the pain running characteristically toward the umbilicus. The gall-bladder was considerably distended with thick mucus and a large gall-stone was impacted in the cystic, at its junction with the common duct. The end of what might be termed a pipe-shaped calculus projected into the joining hepatic and common ducts. The opening into the cystic duct for the removal of stone was successfully sutured, no gross signs of pus being noticeable.

Fearing a too rapid flow of bile through the now enormous cystic duct, I packed this and the gall-bladder very tightly with iodoform gauze. The seat of operation was protected with the same material and the wound left open. Three days later I was summoned in haste on account of another tremendous chill, followed by a temperature of 105°, and an alarming, colliquative sweat with a miserable pulse of 140. On removing the intracystic gauze an enormous gush of bile poured out, since which time there has been no recurrence of the phenomena. The wound healed by granulation, bile in the stools being variable and mostly absent until the fistula closed with the aid of the Paquelin cautery. The slight digestive disturbances, while the fistula discharged all the bile, yielded readily to the administration of ox-gall. The absence of bile did not seem to affect the odor or the consistency of the stools.

Diagnosis.—Catarrhal cholecystitis from obstruction of the cystic duct; gall-stone in latter acting like a ball-valve in the

common duct by projecting into its lumen; long period of chill, fever and sweat seizures.

CASE VI.—Female; married; 59 years old; seen with Dr. Black, of Downingtown, and Dr. O. S. Haines, the medical consultant.

History.—The patient had suffered from biliary colics for years, these seizures being associated previously with deep but intermittent jaundice. After an unusually severe and long-lasting attack, she passed a number of gall-stones, and, since noted, at times, considerable pure bile in the stools. She was never free from pain, tenderness and rigidity below and inside the rib-border, but the recurrences were not associated with jaundice, only a little bile being noticed in the urine.

Operation.—The oblique incision showed a thickened, contracted, intimately adherent, empty gall-bladder with a movable calculus in the common duct. The stone was removed after the stitches had been applied to close the prospective wound in the duct. The gall-bladder was found to connect by a minute opening with the transverse colon. After excising the former, this fistula and the cystic duct were closed by inversion and suture. The abdominal wound was sewed up ten days later. No leakage of bile took place.

Diagnosis.—Cholecystic lithiasis; discharge into colon by ulceration; ball-valve calculus in common duct.

CASE VII.—Female; multipara; about 65 years old; seen with Dr. Van Baun.

History.—She had gradually developed jaundice, associated with emaciation and cachexia, until the pigmentation was of the deepest imaginable hue. Through the thin abdominal wall the much-distended gall-bladder could be seen as well as felt. A tumor was distinctly made out in the region of the pylorus, which was presumed to be behind the stomach (pancreatic) in the absence of gastric obstruction, the presence of tympany over it, etc.

Operation.—A quick cholecystotomy was undertaken, and as her condition would not warrant an anastomosis with the intestine, a biliary fistula was formed. This discharged freely until her death, but the jaundice was only slightly improved. The obstruction was due to a carcinoma originating in the head of the pancreas and matting together the stomach, duodenum, biliary duct, etc., in an inseparable mass.

Diagnosis.—Obstructive jaundice from cancerous involvement of common duct.

CASE VIII.—Young adult male; operated in the clinic of Hahnemann College.

History.—The patient had received a blow in the epigastrium, which was followed by the symptoms of a localized peritonitis. Within the preceding few months jaundice had appeared, which was progressive and continuous. No tumor could be felt, but the gall-bladder was distended and readily recognized. The patient was rapidly emaciating, and reminded one strongly of the conditions found in the preceding case, *i.e.*, malignant common duct obstruction.

Operation.—Section showed the common duct buried in dense fibrinous adhesions. The gall-bladder contained several ounces of thin fluid, and after carefully separating the adhesions, water could be forced through the common from the cystic duct. The fistula and abdominal wound were therefore left open. As it soon appeared that no bile entered the intestine a cholecystenterostomy was done with the upper jejunum, the abdominal wound being sutured secondarily. The jaundice disappeared entirely.

Diagnosis.—Obstructive jaundice from cicatricial contraction outside of the common duct.

Case I. is narrated first, as illustrating the simplest if not the most frequent pathological condition calling for surgical intervention. It is not at all unusual for a gall-bladder packed full of calculi, small or large, single or multiple, to be carried about for years without the slightest discomfort, the first intimation of the condition being found on the post-mortem table. The tendency, however, of such foreign bodies is to cause irritation, or, in other words, a catarrh; but it is equally true that the latter predisposes to or even induces the formation of gall-stones. Furthermore, unlike pure bile, to which have been attributed antiseptic qualities, this catarrhal accumulation furnishes an excellent soil for germ growth, and in consequence the conditions requisite for inflammatory progress are complete. Thus we find in the natural history of cholecystic concretions chronic mural inflammation with its inevitable contraction, producing the small cicatricial gall-bladder, upon which may supervene a more acute process, as in the case narrated. Some

of the other cases illustrate the intra- and extra-vesical infections, as well as the varieties of peritonitis which sooner or later are produced by irritating gall-stones.

While such an accumulation of calculi may work out in the ordinary way, with the consequent colics, or, if of large size, may make for themselves other avenues of escape, it should be borne in mind that the thick, ropy mucus of gall-bladder catarrh may produce seizures which differ but slightly from those accompanying the extrusion of a stone. In fact, the only difference is one of degree and duration, and hence cannot be distinguished from a rapidly-progressing calculus of comparatively small size. I have in a number of instances been able to bring about a complete cure of such catarrhal attacks by draining and washing out the ducts, whether calculi were present or not.

It may not be out of place here to insist on the careful running-water and sieve examinations of all the stools in cases of presumable cholelithic seizures, and the occasional deceptive results of the sweet-oil treatment. Yet, in this case the discovery of gall-stones in the stools was not a necessary preliminary to operation, the indications being the persistent pain and tenderness, without distinct tumefaction and in the presumable absence of hepatic colic. The long-continued vomiting after operation was undoubtedly reflex in character, as it ceased immediately after the removal of the hæmostat. Such a cause is worth bearing in mind after abdominal as well as other operations, especially those about the rectum, vagina, and male bladder and urethra. The worst case of the kind I have ever seen was apparently caused by the vaginal gauze pack after a simple trachelorrhaphy, and the patient described a similar experience after a previous operation of the same kind.

Another symptom was the long-lasting parenchymatous oozing, the hæmostasis being complete as regards spurting vessels and no bleeding points being found in the subsequent dressings. We are taught to look for troublesome hæmorrhage from the aplastic condition of the blood produced by profound cholæmia, but the patient was not jaundiced in the least. On the other hand, I have feared this complication in a number of cases operated on for hepatic or common-duct obstruction from catarrh, stricture, cancer or stone, with the

deepest jaundice, but have never met with undue oozing except in this instance.

IN Cases II. and III. the inflammatory process had gone a step farther, the catarrhal accumulation having become infected and transformed into pus. This infection may come through the circulation or up the ducts from the intestine, stagnation appearing to be a strong predisposing factor, as shown by experiments on the lower animals and as found during operation or autopsy. Of the micro-organisms the omnipresent common colon bacillus plays here, as elsewhere in the digestive tract, its harmless as well as its deadly rôle. The staphylococci, and the streptococci, too, have been demonstrated with varying constancy, and the typhoid bacillus is present in the gall-bladder, with few exceptions, during and after an attack of enteric fever. The latter seem to act in this reservoir as in the post-typhoid, periosteal abscesses of the long bones—inducing, intensifying or reproducing gall-bladder inflammations immediate or remote.

In these operations there is an anatomical element of safety in what has been variously termed the right renal pouch or the subhepatic space. Bounded, as it is, by the liver above, the duodenum and stomach internally, the hepatic flexure in front, the kidney and spine behind, it is walled off from the general peritoneal cavity sufficiently to at least delay the spread of infections. Lined, as it is, by the ascending layer of the mesocolon covering the duodenum and the kidney, and the peritonæum over the liver and spine, its natural outlet is into and down the lateral gutter to the iliac fossa, or even to the pelvis. It is well known that appendiceal extravasations on the outer side of the cæcum are far safer than those coming from the organ when pointing inward, inward and upward, or even inward and downward. This space or pouch is said to hold a pint or more of fluid before it will overflow, and, taking advantage of this, some operators go so far as to dispense with toilet, pack or drainage; others simply introduce a glass tube anteriorly, and still others rely upon a stab-opening in the right loin. In the presence of normal bile such liberties are permissible, as I found in a case of gunshot-wound of the gall-bladder operated at the Hahnemann Hospital, in which there was an enormous extravasation, without peritonitis, after anterior

drainage alone. So, too, in a case of tightly-contracted gall-bladder on a small stone, seen with Dr. Haines, in which it was impossible to do a cholecystectomy on account of firm adhesions, I isolated the space more completely by walling-off the general peritoneal cavity with iodoform gauze, and allowed the bile to pour out from the deeply-situated gall-bladder through and around a rubber drain. It is a different thing when we have to deal with infected ducts and gall-bladder, and here the toilet and protection must be careful and complete, in spite of this anatomical side-track, or diffuse peritonitis will result.

Before leaving the question of the subhepatic space, reference should be made to the immunity of these patients from subsequent ventral hernia. This is true of all subdiaphragmatic operations in contrast with the supra-pubic or supra-inguinal incisions, and permits of imperfect or late suturing, or even of healing by granulation. There is a limit, however, even here, and the attempt should always be made to get at least a fair amount of closure.

The sagging of the abdominal contents from gravity also suggests a valuable aid in operating high up—the reversed Trendelenberg position or a sand-bag under the liver aiding materially, particularly when access is desired to the common or hepatic ducts.

The removal of the gall-stones cleared the cystic duct in both of these cases, so that when the catarrh yielded to drainage—this, undoubtedly, being responsible for the moderate jaundice in Case II.—the bile resumed its normal course and the fistula healed. Such a clearing of the ducts is by no means always possible, nor does the catarrh invariably yield as promptly; for example, Case V., where there was no bile in the stools for weeks. Again, I have seen cases in which the condition of the patient precluded anything more than simple evacuation—the removal of the obstruction being undertaken later on. In one case of empyema operated for Dr. Marsden, I found the cystic duct occluded, presumably by stricture following ulceration, as no calculi were present. Such ulceration is usually due to gall-stones, and the rare instances of stricture develop after their expulsion. Cholecystectomy was not deemed advisable, and the patient has to this day, in consequence, a minute mucous fistula. He persists in wearing a small rubber

drainage-tube, and refuses to have any operation undertaken, as the annoyance is but slight.

While these empyemata are comparatively common, the hyperacute, phlegmonous or gangrenous variety is quite rare, Case III. being the only one I have met with. The symptoms closely resemble those of the acute appendiceal lesions, in that septic peritonitis is soon produced and operation is urgently demanded. The points of difference are the tumor, its location, and the somewhat slower course, for the anatomical reasons already given. Like other acute peritoneal infections, some of these cases have been operated for supposed bowel obstruction, but, fortunately, both conditions demand the same remedy. As elsewhere in the intestinal tract, perforation is not necessary for the escape of micro-organisms, mural inflammation or necrosis opening the door, only not as widely. If, instead of a diffuse peritonitis, adhesions are able successfully to limit the process, an encysted abscess results, and this usually follows the remains of the umbilical vein, and discharges at the navel, where I have evacuated calculi, or it may empty into one of the hollow organs—duodenum, jejunum, colon, stomach, etc. This took place in Case VI., and I have met with one subphrenic abscess originating in this manner.

The cause of the hydrops in Case IV. is somewhat in doubt, as it might have been due to displacement and kinking of the cystic duct, the organ resuming its normal position and straightening out the duct when empty. Besides, the gall-bladder was unusually movable and could readily be pushed into the loin, out of reach. Such displacement is not infrequently produced by tight clothing or an overloaded colon; but if this was the case, the gall-bladder would have emptied itself from time to time and the tumor would in consequence have been intermittent. The previous irregular emptying of the gall-bladder in the manner mentioned is one of the prolific causes of cystic and duct catarrh.

I have seen this same condition associated with a movable kidney in a patient of Dr. Grigsby's, both organs being recognized before operation; but the hydrops was considered the more important, and an anterior incision accordingly made. No obstruction was found, and the bile began to flow at once. As the tumor had been intermittent, it is more than likely that this

was an instance of malposition and kinking. Nephrorrhaphy was subsequently necessary.

Again, this patient was suffering from a coincident, relapsing appendicitis, and I have purposely selected this one as well as Case I., in which a similar condition existed; to these I could add other like observations. Movable kidney on the right side has frequently been found associated with appendiceal inflammation; the relationship has been declared a causative one, and due to pressure on the superior mesenteric vein. But as regards the gall-bladder I know of no similar reports, nor of any attempted explanations. I am at a loss whether to attribute it to a coincidence; to the effect of the digestive disturbances from bile-duct or reservoir trouble; to the grippe epidemics which are claimed by some to have lowered the tone of the appendix, and by others to be responsible for disease of the biliary passages; or to a preceding typhoid, already referred to and noted in some of my cases, to which appendiceal disease appears to bear at times a *post hoc*, if not a *propter hoc* relationship.

Case V. presented the picture we are wont to find in ball-valve, common-duct calculus; intermittent jaundice; chills, fever and sweat; pain running toward the umbilicus, tenderness below and inside the 9th costal-tip, etc. I have met with several instances in which the mistake has been made of treating these ague fits as malaria. I was surprised, however, on opening the abdomen, to find the gall-bladder distended, and it was not until a cystic-duct stone was seen to act as a movable common-duct one, that the condition was explained. It has been said that the antecedent cholecystitis has so impaired the distensibility of the gall-bladder that it is almost always contracted in the presence of a ball-valve common-duct calculus, while it is more or less distended in cystic-duct obstructions. This I have invariably found to be true.

There was undoubtedly present an infective cholangitis, the commonest cause of which is just such a stone, but the process had evidently not gone on to suppuration, as there were no gross evidences of pus, nor the common results, enlargement of the liver and hepatic abscess. Drainage by the way of the gall-bladder is pre-eminently the remedy and the more likely to be successful the earlier in the pathological process it is in-

stituted. The gauze pack demonstrated admirably that the obstructing stone was the cause of the ague fits, as it evidently retained the bile and reproduced the chill, fever and sweat, of which there was no recurrence after its removal.

In Case VI. there was the typical ball-valve stone situated in the ideal position for removal, the central portion, not at the beginning of the duct, nor in the ampulla of Vater, as often happens. The jaundice was relieved by the opening into the colon, and this is an example of Nature's cure in calculi too large to enter or pass the ducts. The pathological steps are, cystic catarrh, mural inflammation, adhesive peritonitis, attachment to a neighboring organ, ulceration or pressure-necrosis, fistula and discharge. It is unusual for the stone to escape into the colon, but when it does so it goes through the capacious intestine, and is passed without causing any trouble. More frequently it enters the duodenum or jejunum, which suggests the ideal location for cholecystenterostomy. These are the calculi which produce bowel obstruction, and I have met with one which was arrested just above the ileo-cæcal valve, another at about the location of Meckel's diverticulum, while a third in the ileum was the pivot for a large volvulus.

As a rule, such a working out of calculi from the gall-bladder takes place without causing any disturbance, but in this instance their escape was coincident with a severe accession of localized inflammation. The subsequent course was characteristic of a movable common-duct stone, with the exception of the jaundice for which the minute opening into the colon acted as a safety valve. Cicatricial contraction would, beyond a doubt, have soon closed this route of exit.

While we are taught to look upon the complexus of symptoms given above as almost pathognomonic of ball-valve common-duct stone, I have cited Case V. to show how one in the cystic-duct can produce the same symptoms, with the exception of the enlarged gall-bladder, and this is easily overlooked, particularly in the corpulent. Even more complete was the deception in a case of stone of the hepatic duct operated for Dr. Closson—the seizures, the intermittent jaundice, the ague fits, and the small gall-bladder—the deciding symptom being the high and deep tenderness. Section showed eleven freely movable calculi in the hepatic duct.

In Cases VII. and VIII. we find the condition similar in many respects, but widely at variance in its causation and effects; common-duct obstruction, continuous and intensifying jaundice, and progressive emaciation or cachexia. In both the gall-bladder was distinctly enlarged, which, with the deepening icterus, is strongly suggestive of malignant disease, as distinguished from calculous obstruction where, as stated above, the jaundice is associated with a contracted gall-bladder. The distended ducts and gall-bladder contained a colorless mucus, for in complete common-duct obstructions the outflow of bile is arrested or reversed on account of the low excretory pressure, and this also explains the fact that the cystic enlargement does not progress beyond a certain point. Here, however, the resemblance ceased, for the woman was of the cancer age and presented a tumor, the recognition of which in this location usually means that it is inoperable. In spite of this, with due consideration of the risk of any operation in such patients, cholecystostomy or cholecystenterostomy is not only justifiable, but even advisable, to relieve the chæmia and to cure the catarrh induced at times by the incurable lesion. In fact this catarrh is often responsible for the jaundice, as it must have been in this instance, and prolonged drainage and washing may so clear the ducts that the bile will resume its normal channel. In similar cases I have observed the coincidence of long-standing gall-stones, the irritation of which it has been claimed predisposes to, if it does not induce, cancer. So, too, this was the only instance of the kind in which I have found no bile-stained fluid in the abdomen, although this probably depends entirely on portal pressure and stasis.

Case VIII., on the other hand, was a much younger subject and gave a distinct history of traumatism and localized peritonitis. It is in the latter respect unique, so far as I know, although inflammatory adhesions of calculous origin often cause cholelithic seizures and call for operative relief. In a similar obscure case, in which I made an exploratory section, the glands about the common duct were tubercular and caused a like obstruction. Incision and curettage were followed by an apparently permanent cure.

In conclusion, let me say to my medical colleagues that sur-

gery offers relief in many conditions of the gall-bladder and bile-ducts hitherto unsuccessfully or erroneously treated or resulting fatally. From the cases cited it will be seen that operation is indicated in calculous cholecystitis; in hydrops, empyema and phlegmon of the gall-bladder; that is to say, in recurring colics, with or without gall-stones in the stools; in persistent pain and tenderness in this region; and even in continued cholecystic enlargements without other symptoms; in peritoneal infections from this source or for the relief of adhesions causing distress or obstruction; in abscesses about the gall-bladder and ducts and in or about the liver; in short, sub-supra- and intra-hepatic suppuration; in the prolonged presence of jaundice, whether with cholelithic seizures and contracted gall-bladder, suggesting common-duct stone, or with enlarged gall-bladder pointing to malignant obstruction; in unyielding catarrhal and in infective or suppurative cholangitis; in fistula, whether mucous or biliary; and, finally, in wounds and rupture of the gall-bladder.

THE FERRIC CHLORID REACTION IN 27 CASES OF DIABETES MELLITUS.

BY CLIFFORD MITCHELL, M.D., CHICAGO, ILL.

(A Clinical Lecture delivered at the Chicago Homœopathic Medical College in the course on Renal Diseases.)

THAT the clinical value of the ferric chlorid reaction in the urine of diabetes mellitus should not be more generally appreciated is not surprising, when we consider the small number of cases of this disease which fall to the lot of any one general practitioner. It is necessary to follow the course of a number of cases with close observation of the relation of the condition of the urine to that of the patient, in order to wake up to the clinical importance of the above-named reaction. Before entering into the subject from a clinical standpoint, a few words are necessary in regard to the proper performance of the test, a matter which is all-important.

Technique of the Test.—It has long been known that in the urine of diabetic coma, and of the condition preceding it, there is present a substance which gives a Bordeaux-red color with

solution of ferric chlorid. This substance has been called diacetic acid, or by some ethyldiacetic acid.

The standard method of testing for it is given at some length in my recent work on the urine (*Era Pub. Co.*, Chicago), on page 233.

For clinical purposes I use a shorter method of my own, as follows: Take two test-tubes of about the same size, and into one pour 4 or 5 c.c. (about one fluidrachm) of the diabetic urine, and into the other the same amount of normal urine. Make up a solution of ferric chlorid, Fe_2Cl_6 , in distilled water. After experimenting on various strengths I have chosen a 20 per cent. solution as, on the whole, most satisfactory for clinical purposes. Using a medicine-dropper with rubber nipple, add three or four drops, but not more, of the 20 per cent. ferric chlorid solution to each of the samples of urine previously measured out into the two test-tubes. (If a graduate is not at hand for measuring purposes, about an inch of urine in each tube will be a proper amount.)

The ferric chlorid solution should be dropped into the urine slowly, drop by drop, and fairly and squarely, so that each drop hits the urine and not the side of the tube. As the drops sink to the bottom they make a cloudy trail, due to precipitation of the phosphates. After the third or fourth drop has been added the upper and greater part of the urine becomes cloudy, but the bottom part is clear. Now, in normal urine this clear bottom part is of a golden-yellow color, but in urine containing diacetic acid the color is a more or less dark-red.

When it is known with certainty that the patient is not taking drugs, the test as above described is sufficient. In these days of analgesic remedies, however, it is not always safe to assume that the patient has not had a finger in the pie of his own treatment. The numerous aches and pains of diabetics are conducive to resort to the various analgesics, and it is precisely these substances which may make the test uncertain.

When, therefore, we are not absolutely certain that the patient is not taking drugs at the time the urine is examined, further procedure is necessary as follows: Four or five c.c. (about one fluidrachm, or about one inch of urine in a test-tube of medium size) are measured out and boiled over a spirit-lamp. The ferric chlorid is added precisely as before while the urine

is hot, and the mixture immediately filtered. In case the red reaction noticed in the first test was due to diacetic acid and not to drugs, the urine now comes through the filter golden-yellow instead of red, and remains yellow, even after further addition to it of a drop or two more of the ferric chlorid.

If on the other hand the red reaction was due to the presence of drugs in the urine, the filtered urine is reddish or will become red after further addition of a drop or two more of the ferric chlorid.

I have made a sufficient number of experiments on the urine of diabetic patients to satisfy myself that the red color due to presence of drugs, as salicylates, in the urine will appear when ferric chlorid is added to the hot urine, but will not appear in the hot urine when the color in the cold was due to diacetic acid. The results of the test may be shown concisely in the following:

A. An inch of cold urine in a test-tube to which are added three or four drops of a 20 per cent. solution of ferric chlorid: (1) If the lower and clearer portion is a golden-yellow color the test is negative. (2) If the lower and clearer portion is reddish or dark-red, either (a) diacetic acid is present or (b) some drug which gives a red color with ferric chlorid, or else other fatty acids, are present.

B. In case the red color appears at the lower part, take another sample of the urine, boil an inch of it in a test-tube, add three or four drops of the ferric chlorid solution, and filter hot: (1) If the urine goes through the filter golden-yellow, and does not turn red when a drop or two more of the ferric chlorid is added to it, *diacetic acid is probably present*. (Further tests may be made as directed on page 233 of my recent work on the urine). (2) If the urine goes through the filter reddish or yellowish-red, or if the latter becomes more red when a drop or two of ferric chlorid are added to it, diacetic acid is absent, and the original red color in the cold urine was due to drugs or other substances. It is, of course, possible that a patient with diacetic acid in his urine might be taking salicylates or other drugs, in which case the conclusion that diacetic acid was absent would be erroneous. When, therefore, the red color persisting in the hot urine is obtained, administration of drugs should cease until the absence of diacetic acid be assured. In other words, two points are essential to be made in the detection of diacetic acid:

I. A red color when cold urine is treated with ferric chlorid solution.

II. Absence of this red color when hot urine is similarly treated.

Substances Interfering with the Test.—As shown above, various drugs passing out through the body in the urine may strike a red color with ferric chlorid, but the red will also appear when the urine is heated beforehand. It is well to consider what these substances are which may be misleading to the inexperienced, as stated in my book on the urine, p. 234; thallin, antipyrin, salicylic acid and phenol (carbolic acid) give the red reaction, as also fatty acids and other compounds.

Dr. Alfred Lewy, of Chicago, has recently studied the action of various drugs which are likely to give the red reaction with ferric chlorid. He tested in my private laboratory some fifty samples of various medicinal agents, to see which ones gave shades of red with ferric chlorid and which did not. His results were as follows: Warner's Elixir Salicylic Compound, Glyco-Thymoline, Sanitas Oil, Tincture of Iodine, Warner's Antiseptic Pastilles, Panerobilin, Chloralamid, Zymocide, Wyeth's Elixir Salicylate of Strontium Compound, Tongaline, Liquid Peptonoids and Week's Saw Palmetto Compound gave color with ferric chlorid in which red in some shade was present. Of these, Sanitas Oil and Warner's Antiseptic Pastilles in solution gave an orange color not likely to be mistaken for the wine-red proper to the reaction; equal parts of Glyco-Thymoline and water gave a pinkish-red, turning brick-red. Panerobilin (one pill in 5 c.c. water) gave an orange color with the ferric chlorid; tincture of iodine gave an orange precipitate; Chloralamid (1 part by volume of Schering's Elixir to five parts water) gave a close imitation of the Bordeaux-red; Zymocide and water, equal parts, gave with ferric chlorid several colors ending in dark violet; Warner's Elixir of Salicylate of Strontium gave a rich violet which, when diluted, became a rich wine-red; Tongaline about the same. Arlington's Liquid Peptonoids, equal parts with water, gave a red-yellow color when the ferric chlorid was added, but the shade was not a wine-red; Week's Saw Palmetto Compound gave a dark-red by direct light, which, however, was muddy by reflected light.

Of all these, therefore, only Chloralamid and the Salicylate

preparations gave reactions which closely resemble the red reaction with diacetic acid.

When, then, the patient is taking Chloralamid or Salicylates, any red color given by the urine when ferric chlorid is added to it should be looked upon as due to presence of the drugs, administration of which should be suspended and the urine tested again.

In confirmation of the above, let me say that I found in the urine of a patient taking Warner's Elixir Salicylic Compound a red reaction with ferric chlorid, persisting in the hot urine. The patient, a diabetic, ceased taking the preparation for a few days, when the red reaction was no longer found in the cold urine, indicating absence of diacetic acid originally.

In conclusion, let me say that the test should always be tried on freshly voided urine.

Clinical Significance.—It has been my experience that but little amelioration is to be hoped for or expected in cases in which the red reaction, present in the cold urine and absent from the hot, occurs.

It may seem rash to stake a prognosis on a single urinary reaction; in fact, I have repeatedly in these lectures protested against jumping at conclusions from insufficient urinary data, but in the case of the red reaction it would appear that we are justified in taking a gloomy view of the case, if it, the reaction, is due to diacetic acid. In my own experience of nearly two hundred cases of diabetes I have no evidence of any noteworthy amelioration ever having been brought about, either by anybody else or by myself, after the diacetic acid persistently appeared in the urine.

On the other hand, when diacetic acid is absent, diabetes mellitus is in my experience the easiest disease to manage in the whole urinary category. The quantity of sugar, no matter how large, can be brought down to 1 per cent. or less, and the patient told "to take up his bed and walk."

Under the influence of appropriate diet and treatment I have repeatedly seen the sugar fall below 1 per cent. in less than a fortnight, and in two instances permanent disappearance of the sugar took place, which has not as yet returned, even in traces. The following list of 27 cases will serve to show the course of the disease when diacetic acid is present, and when it is absent:

Cases.	First Seen.	Ferric Chlorid Reaction.	Present Condition of Patient.
1. Mr. M...	1891.	Absent. None now.	Alive and attending to business.
2. Mrs. G...	Feb., 1895.	Absent. Not found at last examination.	Alive. In fairly good health.
3. Mr. P...	" "	Absent.	No sugar present. Patient well and attending to business.
4. Mr. K...	April, 1895.	Absent.	Amelioration prompt, but present condition unknown.
5. Mrs. S...	Dec., 1895.	Absent, and not found at any time since.	Alive, and in fairly good health.
6. Mr. B...	May, 1896.	Absent.	No record.
7. Mr. C...	June, 1896.	Absent.	Rapid amelioration. Relapse when treatment discontinued. Now better again after resuming treatment.
8. Mr. M...	Sept., 1896.	Absent.	Rapid amelioration. Sugar easily controlled.
9. { Mr. R. Dec. 23, '96. Mr. R. Dec. 26, '96.		Absent. Present.	Patient suffering from gastric crises. Died in six weeks.
10. Boy 19 yrs. old.	April, 1897.	Present.	Died in June, 1897.
11. Mr. G...	April, '1897.	Absent.	Rapid amelioration. Discontinued treatment, and was said to be dying early in 1899.
12. Mrs. T...	May, 1897.	Present.	No record.
13. O. R., girl of 8.	Aug., 1897.	Present.	Died in one year.
14. Mrs. R.	April, 1895.	Present.	Died in 1899.
15. Mr. H...	Jan., 1898.	Absent.	Alive.
16. Mr. B...	March, 1898.	Absent.	Rapid amelioration. Sugar reported to be absent.
17. Mrs. M.	1897.	Absent.	Case stationary until writer's mineral-water treatment taken, when rapid amelioration.
18. Mrs. Mc.	April, 1898.	Slight reaction present.	Died, June, 1898.
19. Mr. Mc.		Absent.	Alive.
20. Mr. L...	Sept., 1898.	Absent.	Alive. Rapid amelioration. Sugar absent in less than a week.
21. Boy 19 yrs. old.	Oct., 1899.	Present.	Died, March, 1899.
22. Mrs. W.	Nov., 1898.	Present.	Died of exhaustion, June, 1899.
23. Mr. E...	Jan. 19, '99.	Absent.	Rapid amelioration. Sugar decreased from 4 per cent. to less than 1 per cent. in a month.
24. Mr. B...	Dec. 30, '99.	Absent.	Rapid amelioration. Sugar decreased from 5 per cent. to less than 1 per cent. in about a month.
25. Mr. M...	June 1, 1899.	Absent.	Remarkable amelioration. Sugar decreased from 7 per cent. to $\frac{3}{4}$ of 1 per cent. in 5 days.
26. Boy of 18	Aug. 5, '99.	Present.	Case obstinate. After a month's treatment sugar still 6 per cent.
27. Mr. M...	Aug. 25, '99.	Absent.	Sugar reduced from 6 per cent. to less than 1 per cent. in a fortnight.

Case No. 1 has been under my observation for eight years, with repeated examination of urine. At no time has diacetic acid ever been found. He is apparently better now than at any time since the sugar appeared.

Case No. 9 showed no diacetic acid although critically ill, having had gastric crises and being very weak at the time I saw him. I suspected that the absence of diacetic acid was but temporary and made repeated examinations. I found it three days later in his urine, and from that time on it was never absent during the remaining six weeks of his life.

Cases 10, 13, 21 and 26 were all young people under 20 years of age. In my recollection, diacetic acid has never been absent from the urine of such young people as I have seen affected with diabetes mellitus. Nor have I seen any of them recover.

In case 26, now living, a slight gain was made; the patient, a boy of 18, gained three pounds in ten days under diet and treatment, felt stronger, and had less trouble from cramps in the legs; but when I saw him last he was passing more than 100 fluidounces of urine, and the sugar was 6 per cent. In Case 11 there was no diacetic acid ever to be found in repeated examinations of the urine. Patient was an old man so tormented by thirst that he sat in a chair in the kitchen, so as to be near the hydrant. In three days or less the thirst was reduced to only a little more than normal. He discontinued diet and treatment, and when last heard from (1899) was said to be dying.

Case No. 27 was a man who had been unable to visit his office in several months. Diet and treatment began on Thursday, and on Monday he was at his desk, where he has been ever since, now three months.

Case No. 3 is apparently cured. Sugar gradually disappeared entirely from the urine, and has not as yet returned.

Case No. 22 was that of a woman in whose urine diacetic acid was found several times. She would not adhere to any systematic *régime*, but drifted about from one thing to another, and died suddenly, in about seven months, apparently of exhaustion. In Case 18 the diacetic reaction was only slight, due perhaps to the fact that no freshly voided sample of urine could be obtained. The writer has no doubt from the record of this

case that diacetic acid could have been found by repeated examinations of freshly voided urine.

From the above list the following conclusions may be drawn:

1. When the ferric chlorid reaction is absent, the amount of sugar in the urine is of little consequence. It may be reduced from as high as 7 per cent. to less than one in five days under appropriate treatment.

2. When the ferric chlorid reaction due to diacetic acid is continually present, little or no benefit is experienced from the same line of treatment which so speedily helps those in whose urine the reaction is absent. Diet, drugs and mineral waters all fail to help the patient; suggestion, mental therapeutics, "faith," etc., were tried by at least one patient in the list, but without avail.

[I notice with interest the researches of De Renzi (*Gazz. degli Osp. e. delle Clin.*, June 5, 1898), who claims that on a diet of green vegetables exclusively, for a day or so, both sugar and acetone vanish from the urine. In the severest cases he restricts the diet to green vegetables alone for two days, then allows a mixed diet of 100 grammes green vegetables, 300 grammes meat, five eggs, and half a pint of red wine daily. Twice a year the patient should restrict himself almost exclusively to green vegetables for a few days.]

THE COMMONER PUSTULAR DERMATOSES, AND THEIR RELATIONS TO ONE ANOTHER.

BY WILLIAM W. KNOWLTON, M.D., PHILADELPHIA, PA.

(Read before the New Jersey State Homœopathic Medical Society, May 2, 1899.)

PUSTULAR dermatoses belong to one family, the relationship being extremely close in some instances. The bond of union that binds these diseases together is the exciting cause, namely, pyogenic organisms. In reading various works on dermatology, one is impressed by the diversity of opinion that exists in regard to many skin diseases; and this is particularly noticeable in looking over some of the pustular diseases, notably, impetigo simplex, impetigo contagiosa, and ecthyma.

Impetigo simplex is described as an inflammatory pustular disease, characterized by pustules of various sizes and shapes, and running an acute course. The disease is pustular from the beginning. The lesions vary in size from that of a split pea to that of a finger-nail; they are usually raised above the surrounding skin, have thick walls, and are surrounded by a slight red halo. There is little or no infiltration, and the process is quite superficial. The disease is found, for the most part, in children, and the lesions are seen most frequently on the face and hands. It is inoculable, auto-inoculable, and, I think, contagious.

Impetigo contagiosa is described as an acute, inflammatory, contagious disease of the skin, characterized by the development of vesico-pustules and pustules which are usually discrete, and vary in size from that of a pea to that of a finger-nail.

This disease usually starts as a vesicle, the contents of which soon become pustular. The disease is exceedingly superficial, and hence the walls of the lesions are thin and flabby. Like simple impetigo, the disease is most frequently seen among children, and occurs for the most part upon the face, the back of the neck, and on the hands.

Here we have two diseases which are so closely related that most authorities look upon them as one. Crocker, in referring to impetigo simplex, says: "I must confess my inability to recognize this disease as depicted by Duhring. McCall, Anderson and Jamieson look upon impetigo simplex as a pustular eczema. Unna considers all varieties of impetigo under one head. Max Joseph also looks upon the two varieties as one.

From my own observations, I am convinced that impetigo simplex and impetigo contagiosa are one and the same disease, impetigo simplex being nothing more than an atypical impetigo contagiosa, and the difference between them being one of degree, and not sufficiently marked to warrant a distinct name.

There is another disease which is very closely related to this family. I refer to ecthyma; but, before considering ecthyma, I wish to call attention to a pustular dermatosis to which I was first introduced while working in the dermatological clinics of Europe. This condition, or pustular disease of the skin, was termed *streptococcic* infection. The lesions of streptococcic in-

fection sometimes approached an impetigo contagiosa in appearance and sometimes an ecthyma; and sometimes a type of pustular disease, hybrid between the two, appeared, with ill-defined lesions, running an irregular course. Thus you see we have a new member of this family.

Ecthyma is defined as a pustular disease of the skin, characterized by one or more pustules, usually discrete, and varying in size from that of a pea to that of the finger-nail, or larger. The pustules are situated upon an inflammatory base, and are followed by thick yellowish or brownish crusts.

The disease is always pustular. The lesions vary in shape, but usually possess a sharp outline. They may attain the size of a twenty-five-cent piece. There is a marked areola about the lesions, varying in color from a bright to a livid red, and extending a considerable distance from the margin of the sore. The process involves the deeper structures of the skin, and there is more or less ulceration. Induration of the tissues about the lesion is present in many cases. The disease occurs for the most part in adults, and is seen most frequently upon the extremities, especially the lower ones. It also is frequently seen upon the buttocks and back.

In speaking of ecthyma, Hyde says the term "ecthyma," like several of the titles of chapters immediately preceding—referring to chapters on sycosis non-parasitica, furunculosis, impetigo and impetigo contagiosa—no longer points to a distinct disease. Kaposi thinks that the pustules of impetigo contagiosa and ecthyma are of a temporary character, and are not independent diseases. Max Joseph recognizes impetigo contagiosa, but considers ecthyma as nothing more than the same process, involving the deeper structures of the skin. Duhring, in speaking of impetigo, says the disease is closely allied to ecthyma, to furuncle, and to cutaneous abscesses in general.

While I think that impetigo contagiosa and ecthyma are one and the same process, yet, the clinical difference being marked, a distinction should be made between them. Here, then, we have a family of four, composed of impetigo simplex, impetigo contagiosa, ecthyma, and the so-called streptococcic infection, which is nothing more than a mongrel type of the others. The relationship between these four diseases is so close that some dermatologists are inclined to look upon them as one, the

difference being only one of degree. They all occur in the same class of individuals, that is, in those who are constitutionally below par. They are all inoculable and auto-inoculable, and I think they are all contagious to a greater or lesser degree. I think impetigo simplex and impetigo contagiosa, resembling, as they do, each other so closely, should be considered as one and spoken of under one name; but that ecthyma, while it is undoubtedly the same process, differs in its clinical aspects, and should receive a distinctive name. Streptococcic infection, being a cross between the two, might be split, as it were, and those hybrids which approach an ecthyma be classed by that name, while those that approach an impetigo contagiosa might be classed as such. As I do not like the term "ecthyma," I would substitute for it the "pyogenic dermatitis." Thus, instead of having four distinct diseases we have two, namely, impetigo contagiosa and pyogenic dermatitis.

Under *impetigo contagiosa* I would include all lesions as described under impetigo simplex and impetigo contagiosa, as well as a large number of pustular lesions impetiginous in character, but more or less atypical. In other words, I would include all superficial, discrete or confluent vesico-pustules or pustules, occurring for the most part in children, resulting from contact with one already infected, or from pyogenic infection, due to scratching or other causes, with which there is associated little inflammation and infiltration of the tissues surrounding the lesions, and in which the areola, if present at all, is slight.

Under *pyogenic dermatitis* I would include all pustular lesions, not follicular, involving the deeper structures of the skin, and accompanied by more or less inflammation, infiltration, and ulceration of the area involved. The lesions may be round or oval, with sharply-defined borders, or they may be decidedly irregular in outline. The amount of ulceration may vary from a superficial erosion to a deep ulcer, involving the whole thickness of the skin, and extending into the subcutaneous tissue. This disease occurs most frequently upon the extremities, especially the lower, upon the buttocks and the back.

To recapitulate, in impetigo contagiosa the lesions are vesico-pustular or pustular, the process is superficial without ulceration, there is little or no inflammatory halo, and the disease is

found most frequently in children, occurring for the most part upon the face, neck and hands.

In pyogenic dermatitis the lesions are pustular; the process is deeper, involving the corium and subcutaneous tissues; there is more or less ulceration, with decided inflammatory areola; and the disease is most frequently seen in adults, occurring for the most part upon the extremities and back.

Some dermatologists are inclined to include in the above family group sycosis, non-parasitica and furunculosis. While there is a relationship between them because of the rôle played by the pyogenic organisms in their production, yet the clinical difference, to my mind, is decidedly marked.

In impetigo contagiosa and pyogenic dermatitis, or ecthyma, if you prefer, the essential parts of the skin are principally involved, namely, the epidermis, the corium, and the subcutaneous tissue; while in sycosis and furunculosis the appendages of the skin are principally involved, namely, the hair follicles and the glandular structures.

Sycosis non-parasitica, or sycosis coccigenica, is described as a pustular disease affecting the hairy regions of the face in the male adult. Other regions may be affected, such as the pubes, the scalp, and the back of the neck. Hutchinson mentions a case in which the entire body was affected. This disease is often described as being papular as well as pustular. In my opinion, those cases in which papules were noticed were cases which had been seen early, or old cases showing the development of new lesions, and, if they had been allowed to go on for a few days untreated, would have become pustular. The disease is distinctly follicular, as, on examination, each pustule is found penetrated by a hair. The disease is undoubtedly due to the invasion of the hair follicle or follicles by the streptococci and staphylococci organisms, and I think a better and more descriptive name would be pyogenic folliculitis.

Furunculosis is described as a circumscribed, cutaneous or subcutaneous abscess. As in sycosis non-parasitica, a furuncle is the result of pyogenic infection of a hair follicle or of one of the glandular structures of the skin. Furunculosis bears the same relationship to sycosis non-parasitica that pyogenic dermatitis or ecthyma does to impetigo contagiosa.

In looking over the chapters on impetigo simplex, impetigo

contagiosa and sycosis, you will notice that pustular eczema plays an important part in the differential diagnosis. To my mind there are no true pustular eczemas; but there may be eczemas presenting pustular lesions, the result of infection. If, then, you have a case presenting impetiginous or sycosiformic lesions, and you are in doubt as to whether you have an impetigo, a sycosis, or an infected eczema, ascertain if there was a pre-existing eczema, and frame your diagnosis accordingly. As I just said, there are no true pustular eczemas, and what applies to eczema applies to acne, syphilis, and a number of other skin diseases which frequently present pustular lesions.

Hebra once said: "All pustules must be regarded as secondary morbid products, and hence are not fitted to form an independent species of cutaneous diseases. There are, therefore, no proper pustular diseases, but only pustules which may occur in the course of or as the effects of many different affections of the skin."

I do not agree with Hebra in that there are no proper or true pustular diseases of the skin. When the infection takes place through a pre-existing abrasion of the skin, as a scratch; when pyogenic organisms invade a hair follicle or a gland duct; or when an apparently healthy skin becomes infected as the result of scratching or otherwise, and a pustule or pustules develop, I think we are justified in considering that we have a true pustular dermatosis. On the other hand, when we have a pre-existing dermatosis, not pustular in character, as a papular or vesicular eczema, and, as the result of scratching or from other causes, it becomes infected with pyogenic organisms, and pustules develop, then we have a false pustular dermatosis.

In closing, a few words in regard to the treatment of these diseases. As they occur in those who are constitutionally below par, either from unhygienic surroundings, improper foods, debauchery, etc., or as the result of debilitating diseases, it should be our first aim to correct as far as possible the predisposing causes. The physician should see that the patient's mode of living is as it should be hygienically; especially that he bathes sufficiently. If the patient be addicted to drink, he must be impressed with the necessity of total abstinence. In the case of a nursling, the way and manner in which it is nourished should be ascertained. If the patient is debilitated from disease, he should be built up. As many cases of impetigo

contagiosa are due indirectly to pediculosis capitis, examine the hair for ova, and, if found, see that they are removed.

Medicinally, no one remedy nor no class of remedies is especially indicated. Prescribe according to the condition and the totality of the symptoms. When there are no constitutional symptoms on which to base a good prescription, such remedies as arsenicum, cicuta, graphites, natrum mur., psorinum, hepar sulph., mercurius, silicea and sulphur will come into play.

Locally, we can do much to remove the existing lesions. If the case is one of impetigo contagiosa, due to pediculosis, it is of the utmost importance to first remove the pediculæ and their ova. I know of no lotion that will do this so quickly and thoroughly as the fluid extract of staphysagria, $\mathfrak{5ij}$ to $\mathfrak{3vj}$ of dilute acetic acid. Common table vinegar will also be found of service. Some recommend an infusion made of tobacco stems. The impetiginous lesions are very easily treated. First the crusts are removed by soaking them in olive oil, and then an ammoniated mercury ointment, 20–40 grains to the ounce, is applied. There are other ointments recommended, but, in my experience, this ointment will do its work quickly and satisfactorily.

In pyogenic dermatitis I generally follow the same line of local treatment as in impetigo contagiosa; but if there should be considerable ulceration, I dress the ulcer surgically, using aristol or iodoform as a dusting-powder.

In pyogenic folliculitis or sycosis non-parasitica we have a more formidable disease to deal with. Shaving is a most important preliminary. A skillful barber gives but little pain, and, after the first time, the patient does not mind it. Shaving should be continued for some time after an apparent cure has taken place.

In very acute cases, after the part has been cleaned, soothing applications, such as a mild calamine ointment, or the oleate of zinc ointment, should be used. After the acute symptoms have subsided, I use either the ammoniated mercury ointment or the oleate of mercury, 1 to 2 per cent., or a sulphur ointment, 20 grains—a drachm to the ounce. But, no matter what treatment is adopted, some cases of sycosis will run for a long time, so that it is well to be guarded in giving a prognosis.

Pustular eruptions in general are treated along the same line as impetigo contagiosa, pyogenic dermatitis and sycosis, avoiding, of course, stimulating remedies in those cases which are acutely inflamed.

PROTARAGOL IN GONORRHŒAL OPHTHALMIA.

BY J. K. M. PERRINE, M.D., PITTSBURGH, PA.

THE following is a report of seven cases treated with "Protaragol."

First, how it should be used. At height of inflammation, for three days a 10 per cent. solution is brushed over the lids with an ordinary camel's-hair brush once daily. Then for the next three days, or until cure is effected, a 5 per cent. solution is instilled into the eyes with an ordinary medicine-dropper. In severe cases the average time for a cure was about seven days, and no complications in any—the generally-recommended cleanliness being strictly adhered to in all cases.

A. G.; age, 11 years. Protaragol brushed on lids for three days; improvement marked after second treatment. After third treatment, with a 10 per cent. solution. A 5 per cent. solution was instilled into eyes. After fourth treatment very little discharge noticed; swelling all gone. Discharged on seventh day, cured. *Atropin*, 1 per cent. one drop daily; *merc. cor.*, 3x every two hours.

D. B.; age, 4 years. This case was treated same as Case No. 1, but treatment was stopped on fifth day. Boracic acid wash was then used for several days. The patient was discharged from the dispensary on seventh day. * *Pulsatilla* 3x every three hours. The only cleansing the eyes got in this case was once daily in dispensary. Parents said they could not control the child at home.

Five similar cases are on record; but they were all about the same, with the same results—two being adults. The treatment was continued for ten days, but after fifth day improvement was so marked that a 5 per cent. solution was substituted for the 10 per cent.

Care was taken to get sufficient data to prove that all the cases were true "gonorrhœal ophthalmia."

EDITORIAL.

WM. H. BIGLER, A.M., M.D.

WM. W. VAN BAUN, M.D.

THE ATTITUDE OF THE MEDICAL PROFESSION TO CHRISTIAN SCIENCE.

THE growth of this latest and most obtrusive of fads is certainly in a way remarkable, although perfectly intelligible. It attacks man in his two most sensitive points, his religious needs and his physical ailments; it offers a panacea for his body as well as for his soul; it guarantees him his future as well as his present. It comes at a time when, within the established religious world, we find a seething upheaval of disturbing doubts and disappointments, which has had the effect of driving many away from their connection with religion and the church and others to a state of indifferent agnosticism; while others, urged by their religious natures, grope blindly about for something new to satisfy their wants; something which shall speak to them with authority, and which shall, at the same time, not be in direct contradiction to their inherited and habitual modes of thought. To this latter numerous class—for man is essentially a religious being—Christian science comes as a saviour, with its few truths, its many half truths, and its mass of wordy crudities and inanities; tying them, by slender threads, it is true, to their spiritual past, holding out promises for both present and future, and with quite enough of ambiguity and mystery to seem to justify its claim to supernatural authority. With this science as a new phase of religious thought we, as physicians, have nothing to do, no more than we have with the attempted advancement of theosophy or the promulgation of any theological tenets; but with it as a method of treatment of diseases we have much to do. In this we have a vital interest, not in the sense of passing upon its merits or demerits, or upon the truth or falsity of its claims, but we are called upon to prevent it from using its religious

garb as a means of gaining privileges and immunities from the State which are denied us. It is this fraudulent representation of their method of cure as an integral part of their religious belief that has made it seemingly so difficult for legislative and judicial bodies to define its exact status before the law. The principle of absolute freedom of religious thought is so engrafted on our national character that anything which savors of interference with it is sure to arouse violent opposition from all sides. The difficulty in treating it vanishes as soon as it is clearly recognized that the adherents of Christian science are free to hold their beliefs without let or hindrance; but that when they undertake to cure disease for a remuneration, they step out of the sphere of religion and enter that of medicine, no matter what means they employ. The means used to cure dare not enter into the question. The effects of attempts to decide the point as to what are the proper means of treating disease has been seen in the past in the disastrous consequences of medical bigotry and intolerance. That period of evolution fortunately, in a great measure, lies behind us, and now all that can be and is demanded of the one professing to act as a healer of the sick is the possession of such medical knowledge and such mental qualification as will justify individual freedom in the choice of the means to be adopted in each case.

It must be rather discouraging to the ardent advocates of State Examinations to find that all their efforts have resulted in placing burdens upon those who, theoretically, should be exempt; while those who are known, both theoretically and practically, to be the ones who should bear them are unaffected. The barriers to the entrance upon the field of medicine are high enough to make it difficult for the honest, educated graduate to pass them, while their construction is such as to allow uneducated quacks and charlatans to creep through them, or the Christian pretender to fly over them on the tenuous wings of his religion. We have, unfortunately—we use the word advisedly—allowed ourselves to be carried along by the hysterical demands for a higher standard of medical education to the extreme limits of illogical and unconstitutional legislation, and all that we can now do is to see that whatever of justice there is in the whole matter be meted out to all

alike. Our legislation says that whoever undertakes to cure disease for pay must possess certain qualifications, the judges of such qualifications to be a body of medical persons appointed by the political party in power at the time. These judges are to arrive at their decision by means of a written examination in each one of a few of the branches of a medical education in which the applicants have already shown themselves competent in numerous oral and written examinations at the hands of their medical teachers, under whose guidance and supervision they have been for four years. Let these requirements be rigidly enforced in all cases, and, whether we believe in their necessity and justice or not, we must be satisfied. They imply a four years' course in a well-equipped and reputable college with competent instructors, the possession of a diploma, and a State Examination, as prerequisites to undertaking to treat diseases for pay. If the Christian scientist, or the osteopath, or the faith-healer, or the magnetic-curer, or the counter-prescriber, or the hydropath, or the electropath, or any of the others who end in "path," can fulfill these requirements, we can have nothing to say.

In the case of Christian science we deem it unwise to seek to oppose its progress by denying its cures. The number of authenticated instances of good results from its method of treatment is too great to be dismissed with a simple denial. The fact that so many of these are reported as occurring in the ranks of the so-called upper classes, those from whose intelligence and education we would expect better things than a recourse to a system presenting at the outset so many glaring absurdities and vaporings, is a stumbling block to many. It would seem that those classes ought to be proof against self-deception, as well as against deception by others, and yet a moment's thought will, we think, explain it. All disease has a psychical as well as a physical aspect, and too often only the latter is made the object of treatment. It is among the cultured and refined, the educated and intelligent, that we find as the result of our present intense mode of living the psychical side of disease predominating and, if not actually the starting point of the psychical, at least, in numberless instances, a decided factor in its continuance and aggravation. To this psychical side Christian science appeals, and by drawing the

attention away from the body, by infusing a hope of relief based on the promise of direct assistance from above, by cultivating new and higher ideals of life, it restores to the mind that supremacy over the sensorium which enables it to cease interfering with nature's efforts to bring about a normal condition. Of course this view of the subject limits the possibility of restoration to health by Christian science methods to those conditions which are not attended by any mechanical or organic changes, and where the nervous element has been the preponderating one, and we think all reported cures will be found to have been of this kind.

Our efforts to stem the course of Christian science, as at present unlawfully carried on, should, therefore, be directed, first, to enlightening the public as to the fact that as healers the Christian scientists do not possess that knowledge of the sciences fundamental to the science of medicine which is considered a necessary qualification in a practicing physician; secondly, to showing, by an appeal to authentic cases quoted, that it was not by any new means or methods that the results were obtained, but simply by such as are well-known, although often neglected, and that these means are not in any sense supernatural, but lie within the reach of each individual who has the will to employ them; thirdly, to showing that it has nothing to do with religion; that a Methodist or an Episcopal physician might just as well claim exemption from legislative enactments on account of his religious views, as a Christian scientist; and, finally, that we are asking nothing but what is eminently just and proper when we demand that the Christian scientist, who proposes to relieve the public of its money and its ailments, should show that he possesses the same preliminary qualifications that are at present required of graduates of medical colleges.

By thus stripping the scientists of their pretensions, by destroying the nimbus of sanctity and mystery which surrounds them,—*omne ignotum pro mirabile*,—and by showing that they are ordinary mortals like ourselves (sometimes very ordinary), and amenable to the same laws, we will arrest the progress of this fad and assist it to a speedy and inevitable euthanasia.

GLEANINGS.

A RARE CASE OF THRUSH OF THE BUCCAL, NASO-PHARYNGEAL AND LARYNGEAL CAVITIES.—Dr. J. Sedziak, of Poland, reports a curious case of parasitic stomatitis, or thrush, in a girl of 15, who, after an attack of diphtheria, became affected with this disease, involving the upper portion of the respiratory passages, *i.e.*, the mouth, nose, pharynx and larynx. The diagnosis was confirmed by microscopic examination of the membranes, where numerous epithelial cells, with the ramifying and filamentous growths of the parasites *odium albicans* were detected.—*Przegląd Chirurgiczny*, tom. iv., zeszyt ii., 1899. How easy it would be to confound such a state with diphtheria. The microscopic examination of the membranes, together with the fact that in thrush the mucous membrane is strikingly dry, would readily lead one into the right track. Borax is the remedy usually employed, and by homœopaths both locally and internally. I have found a solution of boracic acid to act better than borax alone. The acid being uncombined I always believed acted better than the baborate of sodium. Some practitioners use as a local measure a solution of the hyposulphite of soda (one scruple to two ounces of water). Osler calls attention to thrush being noted in the final stages of fever, in chronic tuberculosis, diabetes and in cachectic states. I have observed it in the last weeks of cancer (uteri). Eichhorst—*Lehrbuch der Praktischen Medicin*, p. 152, 1899—speaks of the membranes being whitish or *yellowish*, and that there may be salivation. One to two weeks may be the duration, though in one case, a woman, it lasted one and a half years. In very young children diarrhœa may complicate and become fatal. He calls attention to the fact that sarcina may form similar grayish-white deposits on the mucous membrane of the mouth—stomatomycosis sarcinica. Microscopically the sarcina may be confused with the micrococcus tetragenus. Yet with the sarcina they are four-cornered and lie near each other, while the micrococcus tetragenus has been found inclosed in *one* capsule.

Frank H. Pritchard, M.D.

THE DIAGNOSTIC AND PROGNOSTIC WORTH OF CASTS IN THE URINE.—Dr. Péhu advises in searching for casts not to employ the centrifuge unless necessary, for a conical glass allows them readily to collect at the bottom, while the centrifuge deforms and lacerates them so that especially epithelial casts are torn apart and noticed only as epithelial clumps. If the casts are difficult to detect, hang a few threads in the urine, for casts, like crystals, have a tendency to gather about an object like a thread. From a study of one hundred cases of renal diseases he has formulated the following diagnostic and prognostic rules. He divides them into three classes: Transudation casts, formed by the passage through the urinary canaliculi of certain substances in the blood, and in acute and chronic disturbances of circulation. Thus, hyaline casts are formed which may contain hæmoglobin, fibrin and red blood-cor-

puscles. Desquamation casts, which are dependent on a tearing loose of degeneratively modified cells from the canaliculi; here should be included colloid, amyloid and epithelial casts. Fermentation casts, which are produced by proliferation of the epithelium as a consequence of one or another pathogenic influence.

The granular casts are characteristic of parenchymatous nephritis; even when there are no other signs of an acute inflammation their presence will indicate a nephritis. The other varieties of casts are of less importance in the diagnosis of a kidney disease. Hyaline casts, which are the most frequent, are often found in circulatory disturbances, but of themselves are of no diagnostic importance.

Prognostically, granular casts allow one to follow the course of the disease. They change their appearance according to the acute exacerbations of the disease. In the acute stage they are numerous, very granular, group themselves together and are of a small diameter, which all point to active cellular proliferation.

In the subacute stages the granular casts are fewer, they do not conglomerate, and their diameter increases. When secondary contraction begins to set in, the colloid casts appear. Yet this is no undeviating rule. In the chronic stage the casts decrease in number, and if recovery follow they wholly disappear. If cicatricial changes occur, one may find slight albuminuria *without* casts.—*Hospitaltidende*, No. 29, 1899. In one of the most important and most frequent of kidney diseases, chronic interstitial nephritis, one may search in vain for some time and through many specimens of urine for casts or albumin, particularly if the bowels be acting well and the patient be in good condition. Here the state of the arteries, of the pulse (high tension) and of the heart will be of greater diagnostic value (Osler). Yet if such cases be closely followed, albumin and casts will be finally found (Goodno). I have seen many such cases where the clinical signs and symptoms were plain enough, yet the urine was of good specific gravity, with no casts nor albumin.

Frank H. Pritchard, M.D.

THE DETECTION OF TUBERCLE-BACILLI IN THE FÆCES.—Dr. Rosenblatt advises in cases of suspected intestinal tuberculosis, where the fæces are thin and the bacilli detected with difficulty, that the tincture of opium be given until constipation follow. Then the bacilli may be readily found in the outer surface of the hard lumps where muco-purulent coatings will be found.—*La Settimana Medica*, No. 30, 1899. Ludwig Heim—*Lehrbuch der Bakteriologie*, p. 489, 1898—asserts that the presence of tubercle bacilli in the fæces is not diagnostic of *intestinal* tuberculosis, for they may come from sputum which has been swallowed; again, smegma bacilli may be present in the fæces.

TREATMENT OF BURNS AND SCALDS.—Dr. F. E. Mueller recommends in burns and scalds, instead of the usual preparation, liniment of lime, or Carron oil or dry dressings, ichthyol, applied in a thick layer over the surface. It is then dusted with talc, and a soft dressing bound on. This is left on for three to five days, when all will have healed. In more severe and more extensive burns ichthyol-vasogen is used on compresses, which are changed twice daily. As ichthyol is quite dear, in vast burns ichthyol-vasogen may be used from the beginning, as it is cheaper.—*Wiener Medizinische Presse*, No. 33, 1899.

The old-fashioned Carron oil is good enough for me. A little thymol added makes it antiseptic. Dr. Wertheimer—*Muenchener Medicinische Wochenschrift*, No. 31. 1892—in burns, particularly in children, warmly recommends linimentum calcis (Stall's liniment for burns, it is called in Germany), as it is very anodyne, a first requisite in children. But it is not antiseptic, and the secretions may become purulent, and absorption, with all its dangers, follow. Therefore, he adds thymol, as carbolic acid is not permissible in children (nor iodoform, either, to any great extent). Aqua calcis, ol. lini, āā 50 grammes; thymol, 0.05–0.1. The burned parts are first washed with lukewarm water, broad strips of absorbent gauze are laid over the wound, soaked in the liniment, absorbent cotton then laid over it, and a gauze bandage applied. This should be renewed every day; but as the lime liniment soon becomes a nuisance on account of its "greasiness," towards the end of the second week a bismuth salve had better be substituted.

Frank H. Pritchard, M.D.

NOSE-BLEED.—Dr. G. Stachewicz finds active epistaxis in aged persons to be due to endarteritis, miliary aneurysm, or fatty degeneration of the smaller capillaries, or, if passive, from varices of the septum.

These are frequently caused by the habit of putting the fingers into the nose. Treatment consists in irrigation, tamponing with cotton, and cauterization of the bleeding point (in good light with the aid of the nasal speculum) with chromic or trichloroacetic acid or the thermocautery.

In case of fatty degeneration of the liver or kidneys one should institute general simultaneously with local treatment. In constitutional epistaxis dependent on chlorosis, anæmia and infectious diseases, general treatment alone should be employed, local measures being reserved for vast hæmorrhages. Cases of nose-bleed depending on general plethora, dilatation of the right ventricle, cyanosis, and disturbances of menstruation should be looked upon as favorable.—*Przegląd Chirurgiczny*, tome i., iv., zeszyt ii., 1899. Osler mentions a remarkable case of nose-bleed in a young man where some weeks after an injury to the skull, and after complete recovery, he was seized with a profuse and fatal epistaxis on stooping over to wash his face. The necropsy revealed a fracture of the sphenoid bone with erosion of the carotid artery where it runs closest to the sphenoidal sinuses. In growing children, particularly at puberty, and more often in the delicate than in the strong and vigorous, epistaxis is noted. I have seen a man almost exsanguinated from profuse and recurrent epistaxis from a perforating ulcer of the septum. Nose-bleed is seemingly an unimportant symptom, yet it should not be slighted, for it may be the opening sign of scurvy, typhoid fever, leucocythæmia, pernicious anæmia, etc. West has recently called attention to the occurrence of nose-bleed in old persons as well as in other ages to *contracted kidney*.

Frank H. Pritchard, M.D.

CONGENITAL STRICTURE OF THE RECTUM.—Packard (Boston) records an interesting case of congenital rectal stricture in a child of 3½ years, which had resisted dilatation with bougies. As the bowels were much distended with fæces, left inguinal colostomy was first performed, and the gut thoroughly emptied. Four months later the rectal stricture was incised after removing the coccyx and the first segment of the sacrum, the anal sphincter being preserved. The proximal end of the rectum was brought down and fastened to

the anus with a mucous membrane and muscular line of sutures. A month later the artificial anus was excised and the colon resected. End-to-end union was then made by a continuous catgut suture of the mucous membrane and a Lembert suture of silk for the serous and muscular coats. The abdomen was closed. The patient recovered with a capacious rectum and sufficient sphincter to afford perfect voluntary control.—*North American Journal of Homoeopathy*.

W. B. Van Lennep, M.D.

OBSERVATIONS ON THE DETECTION OF SMALL RENAL CALCULI BY THE RÖNTGEN RAYS.—Abbe (New York), reports two cases in which, by the aid of the Röntgen rays, he was enabled to locate small renal calculi, and verify the diagnosis by successful removal of the stone. He also publishes a list of eighteen recorded cases where the Röntgen rays led to a diagnosis of stone in the kidney.

The first case was that of a man, 27 years of age, who had suffered from pain in the region of the right kidney, right iliac region, and at the end of the penis, since he was 12 years old. This pain had become constant during the last month, and was accompanied with periodical hæmaturia. A fifteen-minutes exposure revealed an unmistakable shadow at the site of the kidney. After exposing the latter by the high intermuscular incision, palpation failed to detect any hardness; an incision through the greater curvature of the organs admitted the finger, but found no stone. It was only after a prolonged careful search with a small probe that the stone was located and removed intact. It was oval-shaped, one-half inch in diameter, and consisted of mixed oxalate and urates. Patient discharged cured in four weeks.

The second case, a woman, 28 years old, married, and the mother of four children, first noticed pain in right side, extending from spine to navel, some six or seven years ago. Severe attacks would occur about once a year, their nature being fever, nausea, chilliness, diminished purulent urine and pain; never passed blood. Several radiographs were taken. Finally one of fifteen minutes gave a fair shadow of a calculus, triangular in shape, between the eleventh and twelfth ribs, one and a half inches from the edge of the vertebra. As in the first case, incision through the greater curvature of the kidney and exploration by the finger was negative. A probe finally found the stone, in the upper third of the kidney, in a pocket of its own, which communicated with the pelvis by means of a small opening. The patient made an uneventful recovery. The stone was of oxalate of lime.

The author states that "to appreciate the meaning of a skiagraph requires as much experience as the technique of taking them." Fresh, delicately sensitive plates should be used, placed well under the patient's back, including the last four ribs, and covered over with rubber tissue to prevent perspiration dampening the paper. As to the machine and tube, whatever will make a good bone-shadow quickly will make a shadow of a calculus; a quick-penetrating focus tube with very short exposure will show stones that would be lost by long exposure. By experimentation, a stone one-eighth of an inch in size, imbedded in a kidney surrounded by four inches of "meat," was successfully radiographed by an exposure of ten minutes.

A wet plate may show nothing, but when dried and held in proper light gives good results. Again, a thin plate, looked at in broad daylight, shows nothing, but when held in front of a brightly-illuminated sheet of clean paper

will give good shadows, or, when moved rapidly from side to side, will often display shadows which would not appear to the observer when held quiet. The fluoroscope is useless. Prints never show as well as the negative, and to properly study the latter the eyes of the observer must be well screened by means of a closed box, something like a fluoroscope.—*Annals of Surgery*.

Gustave A. Van Lennep, M.D.

EXPERIENCES IN INTESTINAL SURGERY.—Matthew D. Mann, M.D., Buffalo, N. Y., relates the following interesting case: The patient, a woman, 23 years of age, unmarried, stated that she had never known what it was to be well since childhood, and for the greater part of six years she had been confined to bed. Menstruation came on late, and had always been vicarious and appeared only at long intervals. Constipation had come to be almost an obstruction. For about one year her bowels had been moved but once per week. At this time she was given a large quantity of Rochelle salts, followed by a hypodermic of morphia, to allay pain. She was then etherized, and physicians administered medicated enemias until a movement was obtained. For seventeen years she had used a catheter, owing to pain in bladder.

A vaginal examination revealed great tenderness in the urethra and neck of bladder. Ovaries swollen and tender, infantile uterus.

In order to relieve the conditions present the following operations were undertaken, the patient making a recovery:

1. Oöphorectomy. 2. Lumbar colotomy. 3. Lateral anastomosis; ileum to sigmoid. 4. Division of ileum near ileo-cecal valve; closure of two ends. 5. Imperfect closure of descending colon below artificial anus. 6. Closure of a median fecal fistula and separation of intestine at artificial anus; complete closure of two ends. 7. Closure of ventral hernia. 8. Same. 9. Same.

Operation No. 1.—Both ovaries were removed, and the rectum and sigmoid were examined as far up as possible without discovering anything wrong. The patient was improved, but not relieved of the bladder and bowel trouble. After a further examination under ether a diagnosis of chronic prolapse of the colon at the sigmoid flexure was diagnosed, for the relief of this condition.

Operation No. 2 was undertaken, being a lumbar colotomy. Great relief was experienced from this, but the annoyance occasioned by the bowel movements caused her to beg for further relief. Her bladder trouble occasioned great pain. For this a permanent vesico-vaginal fistula was made, and the urine allowed to pass in this manner for several months, when the opening was closed. The tenderness had now departed, and she experienced no further trouble from this source.

Operation No. 3.—The small intestine just before it enters the head of the colon was united to the upper part of the rectum, in order to shut off the colon from the circulation. This was unsuccessful, the fecal contents passing through the artificial opening in the abdomen.

Operation No. 4.—The abdomen was opened at the old scar. The ilium was divided a short distance from the ilio-cecal valve. The artificial communication before made was found to be entirely pervious. Both the cut ends of the small intestine were closed by catgut stitches through the mucous membrane, and by Lembert sutures of fine silk through the peritonæum. The abdominal wound was closed by wire stitches in the usual manner.

She returned to the hospital in March, 1891, and reported that the movements were mostly through the rectum, but that a small amount still came through the outside, coming up from the rectum. This gave her great discomfort, and she was ready to try the knife again for relief.

Operation No. 5.—On March 30 she was put under chloroform, the gut loosened around the artificial anus, a portion of the descending colon was pulled up, the mucous membrane freshened, and the edges brought together with catgut. The opening from the transverse colon was left patent. A small sinus was found to exist in the scar of the old median incision, and, following the last operation, it was opened and packed with iodoform gauze.

In April it was found that, since the last operation, feces had been discharging through the side, and also through the fistula in the cicatrix of the former operation.

Operation No. 6.—It was now proposed to again open the abdomen, permanently close the fecal fistula, separate the gut at the point of the artificial anus, and close the lower section securely. This was done April 21, 1891. The median incision was made, the intestine which contained the fistula was exposed, and the fistula closed with fine silk peritoneal sutures. The opening was exceedingly small. The fistula's track in the cicatrix was carefully dissected out. Another incision was then made at the side of the artificial anus, the lower end of the descending colon freed from its attachments, and entirely cut across. The mucous membrane was then sewed with fine catgut suture, and the silk peritoneal sutures introduced. Both wounds were closed with several wire sutures and the usual dressings applied.

The patient's general health at this time was excellent, the bowels moving freely, naturally, and without pain, the bladder giving no trouble.

Subsequently, three operations were performed for ventral hernia, finally resulting in a cure.

She finds it necessary each month to wash out the "cut-off" portion of the large bowel through the artificial opening, but it gives her very little trouble or uneasiness at other times. The cleansing process, she says, is very painful, as a large amount of secretion collects and becomes hard and dry, almost like fecal matter, and of a very offensive odor. If the secretion is not removed once a month it causes nausea, sharp pains in the bowels and extreme nervousness.—*The American Medical Quarterly*, June, 1899.

W. D. Carter, M.D.

A METHOD OF TREATMENT FOR THE RESTORATION OF ENTIRE TIBIÆ NECROTIC FROM ACUTE OSTEOMYELITIS.—Cushing (Boston) reports the case of a boy from whom he removed the entire tibia for necrosis, after the method of Nichols. The operation was done on the sixty-fifth day of the disease. After cleansing the limb and disinfecting all sinuses, the tibia was exposed by an incision along its anterior aspect, and the periosteum—in places much thickened—split along its entire length and separated from the dead shaft of the bone. The latter was then divided at its centre, and the two halves turned out, breaking them away from the epiphyses. After thorough disinfection of all abscess cavities and sinuses by cauterization, curette and irrigation, the periosteal sheath was closed by sutures throughout its length, thus obliterating completely the space previously occupied by the necrotic bone. Where a defect occurred in the upper epiphysis, the cavity was treated by the Schede method. A plaster-of-Paris bandage was used over the dressings.

The wound healed *per primam*, with the exception of two sinuses—one over the site of each epiphysis—which required a second and third operation, and gave considerable trouble before they were permanently closed. A new shaft was formed from the solid cord of periosteum left buried in the centre of the leg, which, on the forty-ninth day, was apparently normal in size and density, and so rigid that the patient could lift the leg from the bed without support. A posterior skeleton-wire splint, extending from the toes to the groin, protected the leg while the patient was up and about on crutches. These supports were discarded thirteen months after the operation, and the leg used freely. Skiagraphy at that time showed the bone straight, but thinner than its fellow, and the medullary canal reformed. Two years after the operation the boy is well, can bear the weight of the body on the leg, and there is only one and three-quarter inches shortening.

The author believes that in such cases, as soon as the infection is checked and the disease well under control, the dead bone should be removed before the involucrum has formed. The most favorable time for its removal is when the periosteum and granulation tissue is in its most active regenerative stage, but before the process of calcification of the bone trabeculae has shut the sequestrum within a compact, dense shell of involucrum. If done too early, the growing periosteum is injured and interfered with; if too late, the rigid involucrum makes the removal of the sequestrum more difficult, and forms a cavity which is very hard to close. The right time at which to operate is best determined by frequent examination of sections of the periosteum with the microscope. It is shown by the presence of numerous fibroblasts, osteoblasts, and small trabeculae in which lime salts are beginning to be developed. In the case reported this stage was reached about the seventh to eighth week of the disease.—*Annals of Surgery*, October, 1899.

Gustave A. Van Lennep, M.D.

SOME EXPERIMENTS RELATING TO STERILIZATION OF* THE HANDS.—Freeman (Denver), after citing the results of a series of experiments made to determine the relative value of the different methods of cleansing the hands, arrives at the following conclusions:

1. None of the methods of sterilizing the hands can be absolutely relied upon.

2. Under some circumstances, much may be accomplished by sweating the hands in a hot-air oven, by wearing rubber gloves for some time prior to an operation, or by immersing the gloved hands in hot water—the object being to produce thorough sweating, which brings any germs that may lie in the sweat glands to the surface, and especially cleanse the subungual space. To do this properly the hands should then be cleansed, and subjected to a second sweating. The procedure will hardly be extensively employed, owing to its inconvenience.

3. Excessive brushing beneath the nails, as much even as the sensitive tissues will tolerate, seems merely to stir up the bacteria when carried beyond a certain point. We can accomplish little by this method.

4. So far, the only reliable means of rendering the hands aseptic is to incase them in sterilized rubber gloves.

Coating the hands with various substances has been tried and found ineffectual.

Cotton gloves, although they soon become contaminated by exudations from the skin, probably do some good, especially if frequently changed, by filtering the bacteria, as it were, and preventing their entrance into wounds.—*Annals of Surgery*, October, 1899.

Gustave A. Van Lennep, M.D.

THE USE OF CHLORIDE OF LIME IN GYNÆCOLOGY. (Petit.)—One hundred grammes of chloride of lime are dissolved in twelve hundred grammes of water and shaken up. It is filtrated after standing and kept in dark, well-corked bottles. A 10 per cent. dilution of the above solution is used for vaginal and uterine irrigation. This solution has the same antiseptic power of a one to a thousand solution of corrosive sublimate, and can be used in all diseases. It dissolves albumin, causes a coagulation of it like sublimate, lysol, nitrate of silver, etc., which coats the surface and prevents the action of the antiseptic on the bacteria deeper in the tissue.—*Revue Internat. de Med. et de Chir.*, No. 1, 1899.

THE USE OF LACTIC ACID IN GYNÆCOLOGY. (Dalché.)—It occurs normally in small quantities in the vaginal secretions. Diluted with an equal quantity of water it has a cauterizing effect. A 3 per cent. solution is excellent for irrigation of the endometrium and cervix, and a 3 per cent. solution with glycerin does good service as an application on a tampon to the cervix. It removes quickly the offensive odor of leucorrhœa, and has a favorable effect on erosions of the cervix.—*Ibid.*

George R. Southwick, M.D.

PUERPERAL TETANUS. (Pit'ha.)—The writer reports a number of interesting cases from the Bohemian Obstetrical Clinic in Prague. Puerperal tetanus is both a traumatic and infectious disease caused by Nikolaier's bacillus (tetanus bacillus), the local growth of which is accompanied by the formation of toxic material which leads to general poisoning of the system. The tetanus bacillus remains at the site of infection, increases under favorable conditions, and early forms spores which remain for some time at the site of infection, and are not taken into other organs. These microbes produce a toxin which is very soluble and easily taken up by the blood, and produces symptoms arising from the motor nerves. The chemical formula of this toxic albuminoid is unknown. There exists a great affinity between these toxic products and the cells of the central nerve organs, and especially of the motor sphere.

Tetanus is always due to inoculation with tetanus bacilli or spores, which are not always located in the uterus alone, and which may be in the vaginal or perineal lesions. Hysterectomy for this reason, even when performed very early, has not resulted in recovery. Serum diagnosis is not possible. Animal inoculation is the best. The period of incubation is usually eight days, but may vary from two to fourteen days. The convulsive symptoms begin with spasms of the pharyngeal muscles and difficulty in swallowing, and gradually extend to the neck, extremities and back. Death from suffocation is likely to occur when the respiratory muscles are affected. Serum injections, intracerebral or otherwise, after the nerve-cells have been affected by the toxin, have no antitoxic effect. The union of the toxin and the nerve-cell is so firm and permanent that the largest doses of serum cannot separate them. The serum is not in this sense anti-tetanic and able to expel the toxin from the nerve-cell. It acts, on the contrary, on the protoplasm of the nerve-cell, so

that afterwards the toxin does not form firm union with the protoplasm of the nerve-cell; *i.e.*, serum injected very early alters the affinity between the nerve-cell and the toxin. The serum is, therefore, of great value for immunization, but is in no sense a therapeutic remedy in the strict sense of the word. Rational disinfection and preventive inoculation are the only valuable means for combating tetanus. Ordinary means of disinfection will not destroy the spores. Alcohol is an excellent agent, as it precipitates the toxin. There were nine cases in the clinic in 1897-1898, all of which were fatal. Preventive injections of serum were then given to all operative cases, and not a single case of tetanus has since occurred, though neighboring clinics have reported cases. It is an established fact that inoculated individuals are immune from tetanus. The inoculations should be given with antiseptic precautions and are without danger. A transitory urticaria may appear at the site of the injection.—*Centralblatt für Gynäkologie*, No. 29, 1899.

George R. Southwick, M.D.

THE PALLIATIVE TREATMENT OF INOPERABLE CARCINOMA. (Gessner.)—There are three important symptoms to control: hæmorrhage, suppuration and pain. The first two are controlled or limited by careful operative treatment of selected cases, which requires narcosis for a proper and exact examination for the extent and complications of the disease. Narcosis should be used for every operation, and the psychical effect is beneficial. Rapidly growing and ulcerating cancers of the cervix as well as of the body of the uterus are suitable for this treatment. Superficial, non-ulcerating, infiltrating cancer is unsuitable for such treatment, as well as all cases in which there is perforation of the bladder or rectum, and also cases where the vagina is extensively diseased at the same time, or if there is deep infiltration of the paracervical connective tissue.

The technique in Erlangen is briefly the following:

1. Disinfection and exposure of the new growth with wooden retractors thinly covered with German silver.
2. Excavation of the growth by removing it as completely as possible up to the dense zone of infiltration by means of the sharp spoon or forceps and scissors, or curved scalpel, and with frequent examination and control of the finger. Hæmorrhage is controlled by sponging with ice-water and tampons.
3. Hæmorrhage is arrested and the walls of the entire cavity are thoroughly cauterized by Paquelin's thermo-cautery.
4. Powdering the cavity with boracic acid and tannin and packing with iodoform gauze. In rare cases a ligature may be necessary.

The immediate result is almost always favorable. A slight rise of temperature was observed in about 28 out of 100 cases, and only once was there an infectious process after opening a centre of suppuration in the cul-de-sac of Douglas. The tampons are removed on the fifth or sixth day without irrigation or wiping. After the cautery slough has separated spontaneously the surface is painted every two or three days with a compound tincture of iodine.

Sometimes the cavity shrinks up almost entirely, and the secretion is helped so much as to frequently lead one to expect recovery.

The use of chloride of zinc as a caustic, in spite of many good results, is not always justifiable, as its depth of action cannot be controlled. Chloride of iron has disadvantages and little to recommend it. Concentrated carbolic

acid (Leopold) and fuming nitric acid (Chrobak) give good permanent results occasionally, but require frequent and long-continued use. The parenchymatous injections (sulphate of copper, corrosive sublimate, alcohol, pyoktanin, etc.), recommended by various authors, so far as tried, have been failures. The sewing together of the curetted surface (Martin, Houzel, Chrobak) is rarely practicable. Results of the Erlangen clinic show only one-fifth of the cases remain somewhat improved. Carcinoma of the cervix in women over 40 years of age show the best results. If a palliative operation cannot be performed but local treatment is possible, irrigation and tampons can be employed. Dry treatment with various disinfectants and astringents in powdered form, interrupted occasionally by irrigations, is especially helpful. Permanganate of potash in a weak solution (1-2 : 1000) is one of the best irrigating solutions. Peroxide of hydrogen and thymol are also good. In advanced stages of suppurated processes large compresses of chlorine water relieve more than the irrigations, which are difficult to give. Nutrition must be maintained and narcotics be avoided to the last.—*Handbuch der Gynäkologie*, f. Veit.

George R. Southwick, M.D.

ALCOHOL AS A DISINFECTANT. (Ablfeld.)—Exceedingly good results have been obtained in the obstetrical clinic and laparotomies in disinfecting the hands of the physician and the skin of the patient by hot water, soap and alcohol alone, and bacteriological examinations show that sterilization is accomplished. Alcohol acts deep in the tissues only when the fat is removed by warm water.

Alcohol is used to sterilize the umbilical cord as follows, as it has a particularly favorable effect on moist tissue. Immediately after labor the cord is tied about 8 c.m. from the navel with a tape taken out of a 3 per cent. soap and creasote solution. As soon as the child is dressed the cord is tied a second time and cut off close, so that only about 2 c.m. remain. This and the surrounding skin is wet with 96 per cent. alcohol and covered with a pad of sterile cotton which is held in place by the abdominal band. The child is not bathed again till the cord drops off, but is washed twice daily without removing the dressing. In several years' experience with this treatment there has never been a single case of infection or suppuration of the navel or of pemphigus periumbilicalis.

Alcohol is a valuable aid in the treatment of inoperable umbilical hernia, as shown in the following case:

A new-born boy at full term showed an abdominal hernia with about 8 c.m. separation of the muscles at its base, with the umbilical cord on top; liver and intestines could be seen in the sac. An unsuccessful attempt was made, with slight narcosis, to reduce the hernia and to approximate the recti muscles. The covering of the hernia and the neighboring skin was sterilized, the hernia reduced as far as possible, and a broad abdominal band applied which would not yield when the child cried.

The bandage remained in place for some time, and was only changed with the same precautions. The belly was first washed with soap and water and rinsed off with sterile water, rubbed with a wad saturated with 96 per cent. alcohol, and then covered with a compress saturated with the same strength of alcohol. The abdominal bandage was applied over all. The process was repeated after a few days, and later a salve was substituted for the alcohol.

The large sac not only skinned over entirely, but retracted to such an extent that only when the child cried was there a projection of a small portion of the abdominal wall. He recommends it in a 50 per cent. solution as a prophylactic for ophthalmia neonatorum. In 500 children, 3 were lightly and 1 severely diseased. It is a rule in each case of fever in labor, and also in obstetrical cases in which long-continued intra-uterine manipulations have been necessary, and especially after intra-uterine removal of the placenta, to irrigate the uterus a second time with a 50 per cent. solution of alcohol. Unusual good results have followed this treatment. Alcohol is used to sterilize instruments, and articles of glass—catheters, bath thermometers, brushes, etc.—are kept in it ready for use; also sounds, specula and dressing-forceps (which are dipped in sterile water to avoid the sensation of burning to the patient, before using). All instruments which come in contact with infectious material are boiled after using.—*Monatschrift für Geburtshilfe u. Gynäkologie*.

George R. Southwick, M.D.

THE ULTIMATE RESULTS IN THE TREATMENT OF GLAUCOMA.—The author has divided the cases into three categories: 1. Inflammatory glaucoma (acute and chronic). 2. Non-inflammatory glaucoma (glaucoma simplex). 3. Hæmorrhagic glaucoma.

The following is a résumé of the most important points in his article: In more than half of the cases of acute inflammatory glaucoma iridectomy was followed by complete cure, and the cases not cured were invariably benefited. According to his statistics, it will be observed that in 62.5 per cent. of acute cases and in 60 per cent. of chronic cases (*i.e.*, inflammatory) a cure was obtained. In only three cases was iridectomy followed by malignant glaucoma, once after acute glaucoma and twice after glaucoma simplex. As regards visual results, a study of his statistics shows that after operation for acute and chronic inflammatory glaucoma useful sight was obtained in 91.7 per cent. of cases. This speaks in no uncertain terms in favor of iridectomy. As regards glaucoma simplex this interesting fact is to be noted, namely, that in 78.41 per cent. of cases after iridectomy and in 60 per cent. after sclerotomy the vision was either improved by the latter or remained the same. While as an operative procedure he puts iridectomy way ahead of sclerotomy, still he thinks the latter a valuable operation, and one that has its indications. He is of the opinion that miotics should always be employed along with the sclerotomy.

What he says of hæmorrhagic glaucoma is interesting, and in this condition he prefers sclerotomy. The statement that in 20 per cent. of such cases cure can be obtained, and in 40 per cent. the condition before the operation maintained, is vindicated by his statistics. These statistics show, by the way, that miotics alone will not relieve the condition, and that sooner or later operation will have to be performed. On the whole, his results are better than most glaucoma statistics, and this he explains by telling us that all the cases were private patients and belonged to the better class of the population. They had come promptly to him as soon as they noticed visual disturbance, and after the operation they could forego work and keep themselves under his eye, a thing which the poor man could not do. (From the private practice of Prof. Haab, of Zurich. Compiled by Dr. Sidler-Huguenin, Assistant Beiträge zur Augenheilkunde, Heft 32.)

William Spencer, M.D.

OTOLOGIC EXPERIENCE DURING THE NAVAL BATTLE OF SANTIAGO, ON BOARD THE IOWA.—Dr. M. M. Simons, U. S. N., first considered the two kinds of powder used on board—the brown prismatic and the so-called smokeless powder. In the brown, some of the grains are unburned, and by the explosion are finally powdered. This dust is often blown back on the decks of the ship, and is sometimes irritating to the mucous membranes. It causes slight congestion, which passes rapidly away. The smokeless powder does produce some slight amount of smoke, or rather haziness in the air, after a discharge of a large amount. Carbonic oxide gas forms in the breech, and when the latter is opened it is changed to carbon dioxide. No ill effects were noted from this gas. After a number of discharges the decks become hazy with the fumes from this powder, and there is noticed a slight though decided acid smell. It is extremely irritating to all mucous membranes, though no serious trouble results. When the decks are washed down after the firing has ceased all this passes away. After the battle of Santiago there were several cases of nasal, tonsillar and ocular inflammations. These were simple, and yielded at once to treatment. A few were deaf, some for from two to four days, but they all recovered by the use of inhalations and Politzerization. Only two cases were observed in which there was rupture of the tympanum. Here there was no pain, but the patient complained of tinnitus. He stated that he was himself slightly deaf as a result of that engagement. When a gun is fired there is a feeling of a sudden blow—something like the blow from a bar of iron.

The two cases of perforation occurred in the vicinity of the eight-inch gun. In his opinion the deafness was the result of the irritation of the throat, primarily, this producing a closure of the Eustachian tube; a subsequent heavy discharge would force in the tympanum, thus forcing out a small amount of air which could not return; and hence the drum would be somewhat retracted, and slight deafness result.

William Spencer, M.D.

FOLLICULAR CONJUNCTIVITIS CAUSED BY THE LONG-CONTINUED USE OF COCAINE.—The patient was a woman who suffered from a slight catarrhal conjunctivitis, and for this was given a solution of cocaine for home use. She soon got worse, and when first seen by the author her appearance was really alarming. There were numerous spots of hæmorrhage on the ocular conjunctiva, and the palpebral conjunctiva was hyperæmic and covered with follicles of unusual size and appearance. Cocaine was at once recognized as the probable cause of the trouble, and this was at once discontinued and a solution of sulphide of zinc, 1-600, was used. Ten days later all the follicles had disappeared and the conjunctiva was much paler, and a month, under simple treatment, the normal condition was restored. This case also shows the bad effect of cocaine on the blood-vessels, which although it causes contraction of the vessels when first applied, yet later on it causes them to lose all tone and to become dilated.

This should warn surgeons to be very careful not to allow the patient to apply cocaine as a home remedy. Although it gives temporary relief, yet its effect on the vessels as well as on the epithelium should prohibit its use for anything but a preliminary to operations.—Prof. W. Koster, of the University of Leyden, *Ophthal. Review*.

William Spencer, M.D.

OPERATIVE TREATMENT OF HIGH MYOPIA.—The author notes the advantage the German ophthalmologists have over Americans for observations of the myopic disease on account of the well-known prevalence of myopia among the Germans. High degrees of myopia (over 12.0 D.) are very rare in America. He minutely describes two patients in whom the operation has been done with most satisfactory results. He concludes as follows: 1. Surgical treatment of myopia should be limited to cases over 12.0 D. who suffer great inconvenience from their correcting lenses. 2. The operations are mainly indicated in young adults. 3. Cases having considerable changes in the ocular structures, such as progressive choroiditis, fluidity of the vitreous, or detachment of the retina, are not applicable for operation. 4. The dangers of operative interference are more than counterbalanced by the results to be achieved, which are: Increased visual activity, enlargement of the visual field and extended use of the eyes, which accompany diminishment of the myopia.—H. V. Würdemann, Milwaukee, *Annals of Ophthalm.* Wm. Spencer, M.D.

TRACHOMA AND RACE.—The labors of Swan, Burnett, Chibret and others show that the races comprising the population of the world vary to a most extraordinary extent as regards receptivity of the trachoma virus, and that this variation cannot be explained by differences of civilization and sedentary surroundings, or even, except in a limited sense, by differences of climate.

It appears to be certain that the Canadian indigenous tribes, including the Esquimaux, are entirely immune; both the specialists and the general practitioners of the Dominion are unanimous in their belief in this absolute immunity. This belief is founded on the fact that oculists of note have never seen a case of trachoma among the Canadian Indians, while other races, living among them under similar conditions, suffer greatly from it.

Pure-blooded negroes, such as those from Senegambia, Guinea and adjacent parts of the west coast of Africa, enjoy a relative immunity as compared with whites. In the United States this immunity appears to be almost absolute, for many authors state that in their experience they have seen either very few or no cases of trachoma among the large black population. The evidence of the receptivity of the white races is too well known to need recapitulation here. Among whites, the Jews, Poles, Italians and Irish suffer most; and here, undoubtedly, poverty, defective sanitation and overcrowding are the main causes of the increased prevalence of trachoma amongst these races as compared with other white races. To the Chinese and Japanese belongs the unenviable distinction of being the most susceptible to trachoma of all races of the world. Meteorological conditions, while they appear incapable of affecting immunity or partial immunity, have an important influence in reducing or increasing the spread of trachoma amongst the susceptible races.

It has long been recognized that, as a rule, the climate of high altitudes is unfavorable to the development and spread of the disease.

Strong sunlight, by producing inflammatory conditions of the conjunctiva, is undoubtedly a predisposing cause. Filth, overcrowding, starvation, and all the conditions aptly summed up by Chibret in one word—misery—are also factors in increasing racial receptivity; they probably act mainly by lowering the powers antagonizing disease, but partly, no doubt, by favoring contagion. Whether trachoma is contagious at all in the strict sense of the word—whether trachoma can communicate trachoma—is doubtful.—M. T. Yare, London, *British Med. Jour.* Wm. Spencer, M.D.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND
THERAPEUTICS.

KALI BICHROMICUM IN RHEUMATISM.—Dr. T. Ord recommends this drug in general fleeting rheumatic pains, which shoot quickly from one part to the other (puls., phyto.); rheumatism alternating with gastric troubles, the one in the fall and the other in the spring, or rheumatism which appears regularly every year at a certain time; nightly rheumatoid pains from tertiary syphilis; gonorrhœal rheumatism, improved by warmth; rheumatic pains in the joints, especially in the wrist and smaller joints. Frequently there is a cracking of all the joints at the least movement; gouty rheumatism.

There may be pain in the loins on the left side; worse on standing, sitting, bending over, or on pressure. It acts best in males (puls. in females). The pains come quickly, and soon vanish; worse in hot weather (better, ign.). Pressure causes pain, which shoots through the whole nerve.

Rheumatic and syphilitic periostitis, nodes on the periosteum, deep-seated bone-pains, caries, necrosis and ulceration of the bones.—*Zeitschrift des Berliner Vereines Homœopathischer Aerzte*, Bd. xviii., Hft. 11, 1899.

Frank H. Pritchard, M.D.

THE DISPENSARY TREATMENT OF PHTHISIS.—Wheeler, in the course of a paper with the above title, discusses his experience in the treatment of dispensary patients, the majority of whom, from lack of means, are unable to obtain the most desirable climatic environment. Deep breathing and a life in the open air, together with a highly-nourishing diet which includes milk and cod-liver oil or cream, are important measures. Of the homœopathic drugs, *phosphorus* disappoints him nearly always. From *iodine*, too, he gets no results, which always puzzles him, seeing how wonderfully it acts combined with arsenic. The *iodide of arsenic* is his favorite—3x trit., 3 grains three times a day. He likes it best in the early stages, when there is much coughing with scanty expectoration, and what there is is difficult to loosen; later on, when the sputum is purulent and comes freely, he prefers *stannum* or *hepar sulph.* *Stannum* was a disappointment until he tried the iodide, but this he likes very well. He recalls the case of a little girl who came into the hospital for acute rheumatism, and was found to have a cavity in one lung and signs of disease in the other. She went out without a sign of disease except that, of course, the cavity, though dry and smaller, was discoverable. He ascribes her cure to *ars. iod.* and *hepar sulph.*, which were given steadily, sometimes one, sometimes the other. She had some doses of *tuberculin*, but she was definitely improving before these were given, and he could not satisfy himself that she made any quicker progress afterward than before. He has given *tuberculin*, in dilutions from twelve to thirty, in nearly every case diagnosed as phthisis. Cases that have it get better, but so do cases equally bad that do not; and when he gets a case that resists treatment he does not find that *tuberculin* clears it up at all.—*Journal of the Brit. Hom. Society*.

F. Mortimer Lawrence, M.D.

THE THERAPEUTICS OF PULMONARY PHTHISIS.—Arnold, of Manchester, at the conclusion of an able discussion of the modern dietetic, hygienic and climatic measures used in the treatment of phthisis, states that the drugs that he personally has found most useful are *sanguinaria*, *jaborandi* and *ioidide of arsenic*. He attaches a very high value to *sanguinaria*, which he thinks has a definite curative action in early phthisis. In several cases in which the sputa contained bacilli, and in which no thorough hygienic treatment could be carried out, he found it of the greatest possible value. One case, a youth who came under his care two years ago, with consolidation of left apex, sputa teeming with bacilli, and drenching night sweats, recovered with extraordinary rapidity under *sanguinaria*, and has for eighteen months past been perfectly well, following his employment as an electrical engineer. A young woman of 25, who came under treatment about the same time with signs of fairly advanced mischief in the left lung and infiltration of the larynx, and who has been taking *sanguinaria* regularly from the commencement of treatment, has more than held her own during that time, and the sputa contain distinctly fewer bacilli than when first examined. The credit of this result, as far as it goes, must, he thinks, be given to *sanguinaria*, for it has been quite impossible to induce the patient to be anything but most abstemious in the matter of fresh air. So far, he has never seen *jaborandi* fail to check night sweats, its action in this respect being often magical in its rapidity and thoroughness.—*Journal of the Brit. Hom. Society*, July, 1899.

F. Mortimer Lawrence, M.D.

KALI BICHROMICUM IN STOMACH DISEASES.—Dr. T. Ord states this remedy to be of service in chronic dyspepsia with hunger or a sense of gnawing in the stomach, a desire for beer, acids and sour foods; the meals taste good enough, but as soon as they are swallowed they lie like a lump of lead in the stomach. A feeling of swelling and fullness; tight clothing is distressing (lyc., nux v.). In the morning there is nausea, disgust for meat, which cannot be tolerated, as well as for water. Sour vomiting an hour after eating, or vomiting of mucus and eructations, the tongue being thickly coated. Chronic gastric catarrh with a thickly coated and yellowish tongue and local tenderness over the epigastrium. At times there will be slight amelioration after eating, but the symptoms return in half an hour. Usually there is aggravation by malt beverages and fats. In more irritative dyspepsia the tongue may be red and clean.

Gastric Ulcer.—Vomiting of blood, frequent burning and painfulness after the least food; great sensitiveness in one point, often at the left of the hypogastrium. Paleness and emaciation. It is especially serviceable in round perforating ulcer of the stomach at the cardiac end.

Cancer of the Stomach.—Cases that simulate a gastric cancer have been cured, and the symptoms of an actual cancer have been relieved with a striking retardation of its course by kali bichromicum (acid. acetic., acid. nitric., hydras.).—*Zeitschrift des Berliner Vereines Homœopathischer Aerzte*, Band xviii., Heft 11, 1899.

Frank H. Pritchard, M.D.

REMEDIES IN BACKACHE.—Dr. R. Staeger advises, in the treatment of this disease:

Aconitum.—Women with plethora, with a sense of "as if it were broken," if it be due to suppression of sweat, cold or anger, associated with profuse and mucous leucorrhœa.

Æsculus Hippocastanum.—Backache over the loins, with great fatigue; motion increases the pain; walking is almost impossible; a feeling of great weakness in the back. Associated with this state is cervicitis; the uterus may be retroflexed or prolapsed, with tenderness, inflammation, and pulsation of its vessels. The concomitant leucorrhœa is darkish-brown, thick, mucous and corrosive. The loins, back, chest, head, heart and abdomen are the sites of reflex symptoms. Aggravated by cold and dampness during the winter, and, as a rule, ameliorated during the summer.

Actea Racemosa.—Violent pains in the lower part of the back—cramp-like pains—which draw from the uterus towards the hips; a pressing sensation in the rectum, as though the rectum would protrude; very profuse leucorrhœa. A peculiar mental symptom is that the patient does not believe that she can be cured, and that she will become insane.

Arnica.—Where a wound or an injury has preceded. A sensation often associated is as if the back and the whole body were broken.

Belladonna.—The backache is usually associated with headache and fever, and is aggravated by movement. Even the character of the pain is acute and tearing or piercing. The pains prevent the patient from lying or sitting.

Calcarea Phosphorica.—Headache and backache in young girls during the periods, where they are associated with anxiety and nervous excitement.

Causticum.—Severe gnawing, boring and drawing pains in the back; burning pains in the external genitals.

Cocculus.—Pains in the back, as though the menses were coming on; drawing sensations and great sensitiveness of the spine; aggravated by walking and bending over. This remedy is especially indicated in blonde women who are capricious and suffer from hypochondria.

Nux Vomica.—The patient cannot tolerate the pain. She is excited and in bad humor; the backache is burning and drawing. A feeling as if it were broken, with sensitive spots in the spine to pressure and touch.

Pulsatilla.—As with all its symptoms, those of the backache are variable. There are sensitive points over the lowermost lumbar vertebræ; drawing pains over the loins, which force the patient to get up and to walk about.

Rhus Toxicodendron.—A sensation of stiffness, lameness and pain in the back, which is ameliorated by warmth and movement. The back feels as if broken; pains in the uterus, produced by cold, dampness and great sweating.

Scpia.—Pains in the uterus, which are especially felt over the loins. The patient sits with her legs crossed, as if she would hinder a prolapse of the uterus. Pains throughout the whole body, which radiate into the back; sudden seizures of pain, when the back feels as if it were broken in two and crushed with a hammer. The pains produce a sense of illness, with weakness and fainting, especially on attempting to get up.

Sulphur.—The patient cannot walk upright; he must stoop over in walking. A sense of tiredness, pricking and stitching in the lower part of the back; colic and painful menstruation. The pains of sulphur are always aggravated by a change of weather and before a storm. *Homœopatisk Tidsskrift*, No. 8, 1899 (Denmark).

Frank H. Pritchard, M.D.

TREATMENT OF PNEUMONIA IN CHILDREN.—Dr. Watkins, formerly an interne of the London Homœopathic Hospital, recapitulates the indications for the remedies which were employed there in pneumonia in children. The drugs are few, and the indications as follows:

Aconite is only used in the very beginning, and should be discontinued as soon as there are signs of hepatization.

Antimonium tartaricum is a capital remedy, especially when there are mucous râles. It should always be prescribed in trituration, as the dilutions rapidly decompose.

Phosphorus is indicated as soon as there is hepatization or the lung becomes drier.

Arsenic. iodatum is of great service when the broncho-pneumonia is of grippal origin, and it is always of use, when the temperature becomes normal, to complete the recovery. When there are symptoms of enteritis or gastritis, the indication is the more formal.

Ipecac. is recommended by Blackly in broncho-pneumonia, even where there is commencing hepatization.

Veratrum viride can only be of service, like aconite, at the very beginning.

Arsenic, preceded by ant. tart., is recommended by Johnstone in broncho-pneumonia complicated by whooping-cough.—*Journal Belge d'Homœopathie*, vol. v., No. 6.

Frank H. Pritchard, M.D.

TREATMENT OF SCARLATINA.—Dr. Lambrechts, Jr., recommends, in the treatment of scarlatina, from his experience in an epidemic of that disease which reigned in Antwerp in 1897 and 1898, the following remedies:

Belladonna 3x as a prophylactic, and during the whole course of the disease in the simplest forms.

Apis 3x, alternated with *aconite* 3x, in the violent tonsillar forms, with intense fever, red and œdematous swelling of or a purulent exudate on the tonsils.

Merc. cyanatus 6x has given him brilliant results in those cases where the deposit took on a diphtheritic appearance.

Bryonia and *cuprum* where the eruption came out with difficulty or serious signs and symptoms developed in the deep organs.

Cold water in effusions was a useful adjuvant where the eruption was slow in appearing and the nerve-centres were affected.

Rhus and *arsenic* were of service where the cases assumed a typhoid appearance.

Ailanthus and *lachesis* were useful in the malignant cases with intense fever, a livid throat, which also might be ulcerated or gangrenous, with purpura, etc.

Sulphur was occasionally of service during the stage of desquamation.

Hepar s. c., *calc. iodat.* and *lachesis* were employed in the consecutive suppurations.

Tuberculinum 6x was found useful in the resultant albuminuria.

China, in the convalescence of debilitated persons, was often indicated, and of aid.

The results obtained by this treatment were satisfactory, for out of thirty patients only two succumbed.—*Journal Belge d'Homœopathie*, vol. v., No. 6.

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KALI IODATUM IN BRONCHITIS.—After a cold on the lungs, with fever, chills, a dry cough and loss of appetite, where acon., bry., were of no aid, and there was dyspnoea, with painful pressure in the thorax, and ipec., ars. and ant. tart. were given without result, kali iod. 3x, four drops a day, brought about a cure within a week.—*Medizinische Monatshefte fuer Homœopathie*.

ARTEMESIA AND EPILEPSY.—Dr. Moeser states that there are three varieties of artemesia.

Artemesia abrotanum, which is of so much service in frost-bites and chilblains, has no influence upon epilepsy. The other two kinds have remarkable curative properties in this latter disease.

Artemesia vulgaris, administered as a tincture of the root in one or two drops, has cured epilepsy, following fright, in a parturient woman. It acts especially if the attacks come on at frequent repeated intervals. The other variety, *artemesia absinthium*, is more active than the *artemesia vulgaris*.—*Ibidem*.

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CALCAREA FLUORATA.—This drug is recommended from the third to the twelfth attenuation for indurations of all kinds. In scrofula when the well indicated remedies do not act in enlarged glands, the fluoride of lime is our chief therapeutic weapon. In styes and other indurations of the eyelids it causes them to disappear with incredible rapidity.—*Revue Homœopathique Belge*, No. 7, Année 25.

KALI SULPHURICUM IN PSORIASIS.—Dr. Oscar Hansen, of Copenhagen, one of the best known Danish homœopaths, and an excellent authority on homœopathic materia medica, was consulted by a glove-maker of thirty-six years who though in good general health had suffered from psoriasis on his right leg first, then later on his left leg and left elbow. The eruption was papular, in oval and annular form with a paler centre. It was covered with whitish scales, burned and itched but little when scratched. After removal of the scales the underlying skin was red and smooth. *Ars.* and *ars. iodat.* were given without much success when *kali sulphuric*, 3x was administered three times a day, and in four months he was wholly cured. The guiding symptom was "great desquamation of the epidermis." Psoriasis is in general a very obstinate affection, and during the years of his practice he has had many cases under observation. The remedies which did best for him were *ars.*, *ars. iod.*, *mangan.*, *phosphor.*, and *sepia*. The first two have yielded the most numerous results, but treatment requires a great deal of time.—*Homœopatisk Tidsskrift*, No. 12, 1898.—*Arsen. bromidat.* is employed by the Russian physicians in this disease.

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COMOCLADIA IN ECZEMA.—The action of this remedy on the skin resembles that of *rhus tox.* It produces erythema, oozing and papular eruptions, though it does not give rise to vesication like this latter, but it may also produce suppuration, especially on the legs. It causes sensations of heat, burning, itching and stinging which rapidly change place and jump about. Aggravation follows contact, scratching, rubbing, and being in the open air. The favorite localization for the swelling and diffuse redness is the face; for the circumscribed patches, the trunk and lower extremities; for the suppuration, the legs.

Comocladia may be indicated in acute erythematous eczema of the face with very marked swelling and partial occlusion of the eyes, or in chronic erythematous eczema of the face characterized by frequent recurrence of swelling of the eyelids. It also is indicated in papular eruptions of the trunk and extremities when the eruption remains papular and becomes neither pustular nor vesicular. From the first to the thirtieth attenuation has been employed.—*Revue Homœopathique Belge*, No. 7, Année 25.

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SOME PECULIARITIES OF THE RESPIRATORY ORGANS IN INFANTS AND CHILDREN.

BY W. H. BIGLER, M.D., PHILADELPHIA, PA.

(Read before the Homœopathic Medical Society, State of Penna., Phila., Sept. 28, 1899.)

THE number of diseases and diseased conditions which are strictly peculiar to infancy and childhood, and which do not occur in adults, is exceedingly small, and the study of Pædology as an independent branch of general medical practice would hardly be justified by an appeal to them. Hence many writers on the subject no longer name their works "Diseases of Children," but, more correctly, "Diseases *in* Children," basing their independent position upon the fact that disease, as found in the adult and forming the proper subject of works on practice, is modified in its symptoms, means of diagnosis, and elements of prognosis, as well as measurably in its treatment, by certain anatomical and physiological peculiarities of infancy and childhood. These peculiarities have in later years been more carefully and scientifically investigated than formerly, and have proved the origin and basis, as they are the only justification, of pædology. That the propriety and necessity of such separate treatment of disease in children has been recognized by the profession is seen from the numerous more or less voluminous works on the subject that have appeared in late years, as well as from the increased amount of time devoted to its teaching in our medical colleges. In medicine, as

well as in commercial affairs, demand and supply are most intimately connected.

The purpose of the present short paper is to draw renewed attention to some of the peculiarities of the respiratory organs in infancy and childhood which influence the manifestations of disease occurring in them, and which are, therefore, of importance in their relation to prophylaxis, diagnosis, prognosis and treatment.

It is well known, but too often forgotten, how important a place among the respiratory organs the nose and naso-pharynx are intended to occupy. In its passage through these organs the air, which is destined to convey to the body the life-giving oxygen, is to be warmed, moistened and filtered. The normal healthy infant breathes with its mouth shut, and is, therefore, dependent for its supply of air upon what can be drawn in through the naso-pharynx. This is relatively long and shallow, and in its respiratory portion very narrow, while the posterior nares are about just large enough to admit the end of a medium-sized male catheter. It can readily be seen how this condition may very materially influence the symptoms and importance of disease attacking these cavities. A simple rhinitis, by the accompanying congestion and extra secretion of mucus, can so occlude the passages as to render the ingress of air impossible, thus compelling mouth-breathing and its attending evils. The air thus inhaled without the preparatory modifications may, and very often does, set up congestion and inflammation in the larynx, bronchial tubes, and even the lungs. Hence in infants and children influenza is so frequently followed directly by inflammatory conditions lower down in the respiratory tract, especially in such seasons of the year when the tempering influences of the nasal mucous membrane upon damp or cold air is particularly necessary. Again, by its interference with nursing, and consequently with obtaining sufficient nourishment, occlusion of the naso-pharynx may cause death directly by inanition, or indirectly by rendering the child more open to infection from other diseases. It has a tendency also in very young children to produce so-called adenoid vegetations, and in older ones their recurrence after removal. An apparently trifling "cold in the head" or "snuffles" in young children is not, therefore, to be lightly regarded, as is too often the case.

A rich plexus of absorbents in the posterior wall of the naso-pharynx, the faucial and pharyngeal tonsils, together with lymphoid masses under the mucous membrane of the posterior third of the tongue, form a ring of lymphoid tissue around the entrance of the pharynx which has an important bearing upon the wider-spread effects of diseases of this region. The peculiar severity of nasal diphtheria is no doubt due to the richness in absorbents found in the naso-pharynx, as contrasted with the comparative poverty in this respect of the faucial tonsils. Besides the danger of systemic infection by the absorption of infectious material here, the mechanical effects of obliteration of the naso-pharyngeal passage by the enlargement of the pharyngeal tonsil are well known—mouth-breathing, malformation of the chest, faulty physical growth, deafness, impaired mental development, etc.

The thorax of the child differs considerably from that of the adult. The ribs run more horizontally in direction, and form the lateral walls of the thoracic cavity, and, in consequence of the imperfect osseous development, the thorax, as a whole, is more elastic and less rigid. It yields, therefore, more easily to pressure from within and from without, and can be expanded in almost any direction. The lumen of the larynx in infants is so small that even a moderate swelling of the mucous membrane will suffice to cause stenosis and call forth suffocative symptoms.

The extent of the bronchial tree in infants and children is greater than that of the air-spaces, and the connective tissue stroma is in greater abundance, with a pronounced tendency to rapid cell division. The mucous membrane of the bronchial tubes is loosely attached to the muscular walls, and the sub-mucous tissue contains an abundance of blood-vessels but loosely confined in its meshes. The alveoli of the lungs are small, with comparatively thick walls and a rapidly proliferating epithelium. The rich distribution of vessels is but loosely restrained in the undeveloped tissue, and hence easily becomes distended and tortuous, and liable to encroach upon the lumen of the alveoli. The absorbents act slowly, the rich blood supply playing the most important part. This loose construction and richness in capillaries render such subjects peculiarly liable to congestion of the bronchial tubes and lungs from atmospheric

changes, excessive humidity, or irritating character of the inspired air. The rapid cell proliferation tends to occlude the smaller bronchial tubes, producing collapse of groups of air-vesicles to which they lead (atelectasia), aggravated by the atmospheric pressure from without, which finds but little resistance in the elastic walls of the thorax.

During the first two or three years of childhood, while the lungs still partake of this embryonal type, an inflammation of the smallest bronchial tubes rarely, if ever, fails to extend to the alveoli, causing a broncho-pneumonia, and the existence of a true capillary bronchitis, without pulmonary involvement, in view of the above anatomical peculiarities, may well be questioned. The rate and rhythm of respiration in infancy and early childhood are very irregular, and variations in them may occur apart from any affection of the respiratory organs. They are, therefore, of less diagnostic and prognostic significance than in the adult. The type of respiration, however, is of more importance. This is normally almost entirely diaphragmatic, or abdominal, and any marked or persistent variation from this points conclusively to some interference with normal respiration. It is also apparent from the foregoing that the amount of dyspnœa in a child cannot be taken as an index of the extent of an existing lesion.

Not until after the fifth year do the lungs assume the adult type, and up to that time we find that children have not the power of voluntarily expelling excessive secretion formed during an attack of inflammation of the respiratory tract. This renders such an attack more serious, at the same time that it calls for special care in the treatment, especially in the way of too energetically hastening by remedies the process of resolution after the period of congestion. In infancy and decrepit old age we may drown the patient by filling the air-passages with secretion too abundant to be gotten rid of.

In applying the various methods of physical diagnosis to the investigation of the diseases of the respiratory organs we will also have to bear in mind the peculiarities to which reference has been made. On account of the small size of the parts, an examination of the naso-pharynx with the mirror for suspected adenoid growths or enlargements will generally prove unsatisfactory, and it is preferable at once to introduce the forefinger

into the mouth, behind the soft palate, and allow it to sweep over the pharyngeal vault. This can be done rapidly and without much discomfort to the little patient, and with satisfactory results for ourselves. The thoracic walls of the young child being thin, vibrations in them are so pronounced that carefully-regulated palpation is often sufficient to detect what process is going on within. By light, medium or deep palpation we can recognize the coarse, sonorous râles of chronic bronchitis, the pleuritic friction sound, and sometimes be able to distinguish between pleuritic effusion and pulmonary consolidation. Palpation is often preferable to auscultation, enabling us to localize the origin of vibrations and sounds more clearly than, or at least as clearly as, with the stethoscope, to the use of which children usually at first strenuously object. In practicing percussion, the resonance of the chest-walls is, again, to be taken into account. A light stroke will give us clearer information than a heavier one, since the latter will bring out sounds from other parts of the chest than those directly under the finger.

For the same reason the results of auscultation, rapid and intermittent as it must be in the case of a crying child, are apt to be less absolutely correct than in the case of an adult, the coarser sounds, as of the trachea and bronchi, tending to mask the finer vibrations. Frequently, however, the very act of crying by the child may assist us in our diagnosis by auscultation, provided due allowance be made for the exaggeration of the sounds both in extent and intensity.

Finally, in locating the respiratory organs we must remember that the trachea lies higher in the child than in the adult, and that the lungs, owing to the encroachment of the comparatively large liver on the right, present their lower anterior border at the fourth or fifth rib on that side, and on the left, at the margin of the sixth. Posteriorly, the lower border extends to the eleventh rib on the right, and as far as the twelfth on the left side.

There are other variations from the adult type of which mention might be made, but as they are rather of interest than of practical importance, they shall be omitted here, those already given being the only ones absolutely necessary to be kept in view when treating diseases of the respiratory organs in infants and children.

THE ÆTIOLOGICAL AND THERAPEUTIC RELATION OF DIET TO ECZEMA.

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Medical College and Hospital for Women, etc.

(Read before the New York County Homœopathic Medical Society, October 12, 1899.)

THE frequent and multiform disease known as eczema must be of interest always to the general practitioner, and a discussion as to its nature is, therefore, not out of place at any meeting of medical men.

This affection has been considered by many authorities as a purely local affection in causation and nature, and by others as due chiefly to a constitutional condition. Both beliefs have been ably defended and sustained by numerous illustrations, and both are, doubtless, in a sense true.

An artificial dermatitis may be excited by external agents, but, in the absence of a systemic proclivity, such an inflammation does not assume an eczematous form or persistency. Experiments of this kind tend to prove that eczema is primarily due to some constitutional dyscrasia, and that external irritants, including bacteria, are purely exciting causes. In another direction there has been little disagreement as to one prominent feature of this common disease, viz., that it is essentially catarrhal. If we accept Jonathan Hutchinson's view, that catarrh is due to a universal diathesis, we may readily understand not only the frequency of occurrence, but the varied expression of this disease. Admitting the general opinion that eczema is a catarrhal affection, and knowing that all secretions, whether normal or abnormal, which arise from the skin originate in the epidermis or its ingrowths, there can be little if any doubt as to the local seat of eczema in this part of the skin.

The peculiar features of the epidermis are: that it is histologically a distinct formation in relation to other structures of the skin; that it is composed almost entirely of epithelium; that it is abundantly supplied with nerves; that it does not contain any blood-vessels—hence, that its nutrition and drainage occurs normally through exosmotic and endosmotic action

from and to the corium beneath; and that, under favoring conditions, it is capable of holding within its substance a comparatively large quantity of liquid or semi-liquid exudate, becoming, as it were, like swampy ground, sodden with fluid, under conditions which increase pressure towards the surface.

It is generally conceded that eczema is an acquired disease. No child has ever been born eczematous; and while there may be an inherited weakness of the cutaneous structures which renders them unable to withstand or resist certain disquieting influences, this is probably the full extent of the effect of heredity as an ætiological factor.

The point to which I wish to call your attention is the influence of diet in establishing a proclivity to eczema, and to what extent a regulation of the diet may influence recovery from the disease. In this inquiry we may exclude the effect of established diseases, such as nephritis and diabetes, which produce characteristic forms of eczema, and which may be, to a certain extent, modified by selection of a diet best suited to the primary or principal disease.

The writer only shares the conviction of others when he asserts that excluding deleterious substances introduced into the system from without, that undue departure from the normal requirements in quantity and quality of food, and its imperfect chemico-vital elaboration within the body, constitute the chief primary causes of disease; and the products resulting therefrom, abnormal in quantity or nature, make up a group of secondary causes or toxins capable of originating through contact or disturbed sensation, functional or organic disorders.

In eczema and in some other affections an acquired proclivity is due to a more or less persistent retention in the body of an excess of by-products or end-products of metabolism, which may be toxic in their effect, and therefore named toxins or endogenous toxins. Any toxin held in solution in the blood which is capable of passing with other constituents by exosmosis from the blood-vessels of the corium into the epidermis may, by its presence, excite a catarrhal inflammation; or, without direct contact with the cells of the epidermis, may act on the peripheral nerves, or more remotely on peripheral centres of innervation, disturb vascular and trophic functions, and produce like results, as in so-called neurotic eczema. It cannot be

proved that a proclivity to eczema is always due to a single toxin or product of the vital processes within the body; rather, it may be claimed that it is due to different toxic substances or conditions in different cases. Uric acid, for instance, probably stands in ætiological relation to eczema, as it does to gout, nephritis, high arterial tension, and possibly to rheumatism.

We can discuss the relations of food to eczema by studying the peculiarities of diet at ages when eczema is most prevalent.

During the infantile period of life, from birth to the fifth year, inclusive, nearly two-fifths of all cases of eczema which occur in that period appear in the first year, decreasing each year up to the end of the fifth year, and then continue relatively infrequent until after the twentieth year.

If eczema occurs during the first year of life in an infant nourished at the breast, we must look to the condition of the mother for the probable predisposing cause. In many cases we will find that there is very little care exercised as regards diet on the part of the mother. She probably is at that period of life when growth has entirely ceased, and the demands of her system are only to maintain an even nutrition and supply food for the child. She may, therefore, have accumulated an excess of uric acid or some other element in the system due to defective metabolism, excessive use of tea, coffee, etc.; or an investigation may show that her secretions are contaminated by lack of proper elimination. In a few cases it will be found that there is defective nutrition, some element of the system not being supplied in sufficient quantity to maintain a normal secretion of the lacteal fluid. Whatever the state may be, *one* indication is plainly to correct, through the necessary change in diet, the condition of the mother in order to reach the eczema in the child.

In bottle-fed infants, I believe, the disturbing element is often an excess of lactic acid either from a too free use of unmodified or sterilized cows' milk, or an over abundant use of sweet or starchy food. Devitalized foods alone do not furnish proper nourishment for a child, and, if we must sterilize, we should assume that disturbance of nutrition is liable to result from the use of such foods, and should include in the diet some article to prevent at least the development of scorbutus. Selec-

tion of food elements corresponding to human milk, only partially devitalized, and the occasional use of fruit juice, has made easier the cure of infantile eczema.

From the fifth to the twentieth year eczema is relatively infrequent. This is a period of life when the demands of growth, nearly or quite equal, sometimes exceed the capacity of the digestive organs. The glandular functions are increasingly active, and errors of diet easily arouse an occasional functional storm which temporarily cuts off the supply and cleanses the channels of nutrition. In line with these physiological facts, most of the cases of eczema at this period are acute or subacute, and diet restriction or regulation is least demanded. Simple equalization of food elements according to the needs of the individual usually cover the indications in this direction.

In the decades of life from the twentieth to the fortieth year about one-third of all cases of eczema occur, and it is a frequent affection up to the fifty-fifth year; in fact, in proportion to the percentage of individuals alive, the largest number of cases (after the first year of life) occur between fifty and fifty-five. The longer period, beginning with maturity and continuing until the modifying influences of age appear, and during which vital resistance is greatest, yields conditions which develop eczema with most frequency (after the first year), notwithstanding the constantly diminishing number of individuals alive as this period advances.

The strain of mature life may hold some causal relation to the greater prevalence of this disease, but the chief causal factor is diet. Males between twenty and twenty-five are subject to more strain, as a rule, than females, and have fewer opportunities to indulge in errors of diet; yet in private practice more than twice as many cases occur in females than in males in this half decade. The predisposing cause of eczema during mature life is often moderate auto-intoxication, sometimes temporary, frequently prolonged. This condition may arise: (1) from a rapidly lessening demand for constructive food after maturity, the diet remaining practically unchanged, (2) from a more or less lessening of bodily activity without other counter-balancing change in habits, (3) from obstacles to elimination, and (4) from increased bacterial activity in the intestinal tract. The influence, degree, and importance of each

or all of these contributing factors may be determined in each case, and the diet will usually be found to stand in a positive or negative relation thereto. I cannot illustrate better the positive relation of diet than by referring to a case sent to me from the country a few months ago. The patient, a man of thirty, well-developed, and having the appearance of more than average vigor, complained of a very troublesome eruption on his legs and arms, and which had resisted all measures of treatment. The cutaneous lesions and the history of their evolution both indicated a disturbance of the peripheral nerve-centres, but no other neurotic symptoms were present, and the primary cause was evidently not of nerve origin. His history revealed that, at the age of eighteen to twenty, he was in delicate health, and that by systematic exercise, considerable outdoor life and forced feeding he had gradually attained vigor and a fine physique, but that since last autumn he had been less physically active, occasionally suffered from constipation, and happening to be very fond of eggs, and having an abundant supply at his country home, he had for weeks substituted them for meat to the extent of one-half dozen or more a day, five or six days in a week. Eggs are very rich in lecithin, which is easily decomposed by bacteria when intestinal activity is diminished, and one of the products of decomposition is choline, which resembles muscarine in action and has considerable toxic power.

It was only necessary in this case to select a diet rather rich in alkaline constituents, and to flush the intestinal canal, to lessen and gradually remove the cause and afford relief. Then an indicated remedy rapidly cleared the skin.

After the fifty-fifth year of life, eczema becomes less and less frequent as age advances, and is quite rare after eighty. The few cases after sixty are mostly secondary to other affections, and some others are cases of pruritus wrongly termed eczema.

While a regulated diet may and often does aid in relieving the eczemas of old age, I am not prepared to say that diet enters into the aetiology of cases occurring late in life, neither do I wish to be understood as affirming that diet is always a factor in the causation at other ages, but that it is a frequent one I am firmly convinced. The statistics as to frequency of eczema

at different ages here quoted were taken from Bulkley's Tables,* but correspond in essential particulars with my own observations.

THE NEED OF A STANDARD PHARMACOPŒIA.

BY CHARLES MOHR, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society, State of Pa., Philadelphia, Sept. 27, 1899.)

As long ago as June, 1868, the pharmacists of the homœopathic school recognized the fact that "in homœopathic pharmacy it is of great importance that there should be: First, UNIFORMITY OF PREPARATION; Second, UNIFORMITY OF NOTATION; Third, UNIFORMITY OF MEASURE;" and at a meeting of homœopathic pharmacutists, attended by William Radde, F. E. Boericke, John T. S. Smith, G. W. Smith, A. J. Tafel, Henry M. Smith and others, an association was formed and styled the "American Institute of Homœopathic Pharmacy," for the purpose of securing such uniformity. Other meetings were subsequently held, and the co-operation of physicians was believed to be absolutely necessary, Dr. F. E. Boericke stating that "the physicians should take the initiative, state what medicines they wanted and how they were to be prepared, and that the pharmacutists should follow their directions." The records of a meeting held at Cincinnati, June 30, 1869, show that the principal pharmacists of the country were unanimous in the opinion that a pharmacopœia would be most valuable if gotten up by the co-operation of physicians and pharmacutists. At this same meeting the society was informed that the American Institute of Homœopathy had appointed a committee to devise a plan for the publication of a pharmacopœia, and requested a conference with the committee appointed by the American Institute of Pharmacy, consisting of J. T. S. Smith, H. M. Smith, F. E. Boericke, A. J. Tafel and G. W. Smith.

Notwithstanding numerous conferences and the appointment of committee after committee by the American Institute of

* "Neurotic Eczema," by L. Duncan Bulkley, M.D., *Journal of the American Medical Association*, April 16, 1898.

Homœopathy, it was not until 1897 that the *Pharmacopœia of the American Institute of Homœopathy* was published, and Pemberton Dudley, M.D., and Eugene H. Porter, M.D., President and Secretary, respectively, of the American Institute of Homœopathy, in the Introduction, commend the work, on behalf of the National Association, as "useful to physician and pharmacist, student and instructor," because it would promote "uniformity in the strength and quality of medicinal preparations."

After thirty years of earnest discussion and hard labor by such physicians as Carroll Dunham and Jabez P. Dake, and such pharmacists as F. E. Boericke and A. J. Tafel—not to mention the score or more of other disinterested and efficient workers—it would seem that the work above mentioned, issued by authority of the American Institute of Homœopathy, should be received unqualifiedly as the standard pharmacopœia. Such, however, is not the case, as there have been many criticisms and rebellions; but, it is to be noted, not so much in the spirit of progress and science as in the prevailing spirit of the commercialism of the times.

There are about twenty-five pharmaceutic firms now doing a large business in the United States, growing rich in providing the practitioners of homœopathy with the preparations required by them; but, instead of invariably furnishing medicines uniform in strength and quality—so consistently and insistently demanded by the votaries of homœopathy—they are furnished with preparations made according to the methods of more than a half-dozen different authorities. And, worse than all, latter-day practitioners of homœopathy, perplexed and confounded by the divergent views of physicians and pharmacutists of their own school as to the relative strength of tinctures, the preparations of dilutions from triturations of insoluble substances, etc., are deliberately buying tinctures, fluid extracts and triturates from ordinary manufacturing chemists and pharmacists, and then, when cases do not respond to medicines if administered according to a symptomatic resemblance of disease phenomena to drug phenomena as recorded in provings, the provings are discredited, and homœopathy itself is condemned by its own practitioners.

The further progress and success of our school of practice

demand that *one* Pharmacopœia shall be the accepted standard for all official preparations throughout the United States, and from every homœopathic pharmacist in the country the homœopathic physician should be able to procure these at any and all times.

At the last meeting of the American Institute of Homœopathy, held in June, 1899, at Atlantic City, the official Pharmacopœia received a due share of attention, and after a discussion of its merits and demerits, the latter being found of minor importance, it was resolved to authorize the printing of a second edition, corrected under the supervision of a committee of revision, consisting of a number of well-known physicians and pharmacists.

This action, following so soon after the appearance of the first edition, is expressive of the need of the homœopathic school. Indeed, in its attempt to unify homœopathic pharmacy by the publication of a standard guide, the American Institute of Homœopathy should receive the hearty thanks of every physician, and every loyal homœopathist should procure medicines only from pharmacutists who follow the official Pharmacopœia in their preparation, for on such concerted action depends the scientific stability and progress of homœopathy itself.

CAN HOMŒOPATHY CURE MALARIA?

BY JOSEPH C. GUERNSEY, A.M., M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of Pennsylvania, Philada., Sept. 26, 1899.)

CAN Homœopathy cure Malaria? Yes.

1. What causes Malaria? We have just witnessed a most interesting and instructive display of the *Plasmodium Malariae**—what is this *Plasmodium* but a germ! Homœopathy cures other germ diseases—why, then, should it not cure Malaria?

2. Homœopathic literature teems with reported cures of Malaria in all its stages, under all conditions, and irrespective of environment.

* Referring to a demonstration by The Saturday Night Club of Medical Microscopists, with the aid of the electric Micro-projection lantern, showing the *Plasmodium Malariae* in its various stages of development.

3. What is Malaria? That is, what is the Malaria that we, as physicians, have to meet and cure? The question is answered by Hahnemann in his *Organon*, where, Section 6, he declares, "For the physician, the totality of the symptoms alone constitutes the disease." And as a corollary to this proposition he asserts, Section 18, "The totality of the symptoms is the sole indication to the choice of the remedy." Viewing Malaria from this standpoint, it renders the (so-called) disease amenable to treatment perfectly. Viewing Malaria from this standpoint, we have nothing to do with the *Plasmodium Malariae per se*, but only with the symptoms that present themselves in more or less harmony, and with more or less regularity and fixedness, to produce what is known as Malaria. Thus we have certain well-established phenomena which must appear in order to produce a picture which can be recognized as malaria, *e.g.*, the chill, the fever, the sweat, the periodicity of the paroxysm, etc. On these threads hang groups of symptoms which may, and which do, diverge so widely that in a dozen or more cases of malaria a dozen or more different remedies are required. It is not necessary to search for remedies which will act as antidotes or germicides to the plasmodium malariae, any more than it is to search for antidotes to the germ of scarlet fever or small-pox, since we have a treatment based upon an absolute law of cure that "the presenting symptoms alone constitute the disease" (as stated above, Section 18). Turn to our rich and certain *Materia Medica*, noting all the groups of symptoms as revealed in our provings; if a doctor knows how to wield this weapon, he will certainly wipe out the symptoms which are known as Malaria.

In connection with the choice and the administration of the similitum remedy comes a most important consideration, *viz.*, *when* shall the remedy be administered? Shall it be before, or during, or after the paroxysm? Or shall a remedy be chosen and then continuously administered, every few hours, irrespective of any proper time? Dr. Henry N. Guernsey won great success in the treatment of malaria, and his rule was to administer his remedy, a single dose in a high potency, as soon as possible *after* the paroxysm had passed over.

Perhaps the reason *why* the best time to give the remedy is after a paroxysm may be found in the following circumstance.

The malarial germ gains entrance within the red corpuscle, and there it grows, developing pigment granules at the expense of said corpuscle, which it gradually destroys. The malarial paroxysm always coincides with the sporulation of a group of parasites. *Hence, directly after an attack, before new parasites begin to develop, is the proper time to administer the similimum.*

In that valuable book, Jahr's *Forty Years' Practice*, the author lays special stress upon the *time* of administering the remedy. He says: "I almost always begin the treatment of a case of intermittent fever with ipecacuanha, unless some other remedy is distinctly indicated. I dissolve three globules of the 30th attenuation, and give a teaspoonful every three hours, *commencing immediately after the chill*; by pursuing this course, I have cured many cases of fever and ague by the first prescription, thus saving myself a good deal of unnecessary seeking and comparing." Ipecacuanha is almost a specific where the symptoms of malaria have been suppressed by quinine. In my own practice, I have found ipecacuanha a most useful remedy in malaria, and especially where, with the chill and fever, there is much gastric distress—nausea and vomiting, or if there is persistent nausea without vomiting—or, though vomiting occurs, the nausea remains unrelieved.

Many able practitioners of our school testify heartily to the efficacy of this remedy in the treatment of Malaria, and H. C. Allen, in his *Therapeutics of Intermittent Fever*, says: "Ipecacuanha covers a much larger range of symptoms than quinine." Especially is ipecacuanha to be thought of in cases where a relapse is due to dietetic irregularities—and we must remember that many a convalescent from chills and fever has caused a serious relapse in his case by injudicious diet. I am not discussing the general treatment of Malaria, but I cannot help referring to the necessity of exercising supreme care on the day of paroxysm—I mean, if the chill, fever, sweat, etc., come every third day, the physician must exercise special precaution on that day. In a case of chills and fever, it is highly advisable for the patient to remain in bed as long as any febrile symptoms present themselves; such a procedure renders the attack of shorter duration and of less severity. But where the patient cannot or will not consent to this, it is all important to insist that he keep in bed on the day of the paroxysm, even

though he be up and around the "well" days; also he should be warmly clothed on that day, and guarded against every draught of air; let him live on low diet that day; make him avoid all excitement and company on that day, sleeping and lounging as lazily as possible.

Even if the physician has apparently cured the chill, it is well to continue these precautionary measures on the day the chill would otherwise have come, for fully ten days or two weeks. Anyone who is subject to chills and fever should invariably sleep in an upper room—the higher the better.

Sac. lac. is the best remedy to administer if, owing to circumstances, it seems needful to give something immediately to ease that tremendous chill or to cool that burning fever. The physician who knows that Malaria *can* be cured by Homœopathy, and who proposes to cure it by Homœopathy, is very chary about spoiling his case by giving many remedies. He has learned that the proper way is to first get all the symptoms; then he applies his remedy, carefully chosen from the *Materia Medica*, in accordance with § 235 and § 236, in Hahnemann's *Organon*, where we read "With respect to intermittent fevers . . . the best, the most appropriate and serviceable method in these diseases, is to administer the remedy immediately, or very shortly after the termination of the paroxysm." I regret that I have not time to read *in extenso* Sections 235 to 244, inclusive, because no physician can truthfully assert that Homœopathy is unable to cure Malaria until he has diligently studied the portion of the *Organon* just referred to and has faithfully applied its precepts to practice.

I well remember the case of a little boy who had a severe attack of chills and fever. His mother drew my attention to the fact that always, when the chill came on, he would creep into her arms—either from the floor or from the bed or from anywhere he might be—would creep into her arms and make her hug him tight to her breast all through the attack. This symptom, which proved to be a "keynote," led to the consideration and administration of Ignatia, when a wonderfully prompt and complete cure resulted. I recall another case, that of a young man who had been camping and fishing on the banks of the Susquehanna. His case proved stubborn, until I learned that he was a "big feeder" (he ate much and

ate often) and had many gastric symptoms. I exhibited Ipecacuanha 200, and an immediate cure resulted.

My father once sent me to see a case for him; he said, "Go over the case carefully, and see if you can find any new symptoms that I have failed to ascertain. If you see your way clear, prescribe; and I hope you will cure her." I visited the patient, found she ate enormous quantities of salt, and gave Natrum Muriaticum 265 m. An immediate cure was the result. Other cases I have had which I have happily cured at the very onset of the attack, where a well-marked chill, fever, sweat, headache, etc., developed and gave me every reason to diagnose Malaria.

I know that in the foregoing remarks I have quoted the experience of many of you; and my only reason for speaking is to encourage some faint-hearted ones, who would like to *cure* their cases instead of partially alleviating or entirely suppressing them.

TESTS FOR THE DETECTION OF ALBUMIN IN THE URINE.

BY F. H. PRITCHARD, M.D., MONROEVILLE, OHIO.

DR. C. R. NORTON, in his article in the July number of the *HAHNEMANNIAN MONTHLY*, in speaking of the reliability and usefulness of certain tests for albumin, gives four—heat, nitric acid, the nitro-magnesian, and the ferrocyanide tests. I can confirm much that he has said, but there are other points which make success more certain which might be worth one's while to bring forth.

In making these tests, I divide my test solutions into rough and delicate. Where albuminuria is pronounced, the *nitric acid* test is my standard. The acid should be used cold, and placed at the bottom of the tube. Then, by means of a pipette, the tube held on a slant, the urine is carefully allowed to run down on to the acid, thus assuring a clear-cut ring of contact. If the ring does not develop in a short time, it should be set aside for a half to one hour, when results may be expected which would not appear immediately. In parenchymatous nephritis, both acute and chronic, as well as in diffuse

nephritis, this method will usually reveal albumin. But it must be present in a fair quantity, and it will not suffice for detecting mere traces. Sir William Roberts and R. T. Ruttan, lecturer in chemistry at the McGill University, advise one to discard all other tests except heat and nitric acid, yet admitting that they precipitate other bodies than serum albumin and serum globulin. This, however, holds true of the other tests.

Nitric acid will also give one a fair idea of the quantity of indican excreted, for a bluish ring will form below the point of contact. This I have noted in cases with constipation, and particularly where there is associated fermentation in the bowels.

In testing with nitric acid, one at times meets with nucleo-albumin, which is evidenced by the formation of a collar some distance above the point of contact. Though distinct like that of albumin and allied in composition, yet it is not albumin.

Heat is quite a delicate test. I fill a test-tube half full, and boil the upper portion, thus insuring against its boiling over, though now and then some urines will "bump" suddenly up and out. Why this is, I do not know. In fact, the more that I use heat and contrast the upper and lower portions of a half tube of urine, the more I am inclined to use it. If long heated and looked at in a dulled light that no lights nor shadows are formed, so that one sees clearly through the urine, good results are gotten. But whether to acidulate before or after boiling is a question. I have found, and my friend, Dr. F. Burt, of Norwalk, also has noted, that if one acidulate before boiling, then the albumin does not stand out as clearly as if it be added afterwards; but if added afterwards, the ring is liable to be less distinct if present in slight quantity, and if phosphates be present, their effervescing may disturb the distribution of albumin and embarrass one's judgment. Mucus at times bothers one. It seems that albumin is present, yet there is such a mucous cloud that one is not certain as to quantity, and, indeed, whether albumin be actually present. It must be filtered out before testing. At times one may centrifuge some of it out, but that is rarely so satisfactory. Phosphates are, of course, eliminated from the field by acidulation.

I never have used the magnesian nitric acid test much, though from that little that I have employed it, I have not been as much

impressed by it as by others. The potassio-mercuric iodide test is handy and quite delicate, but it is said to precipitate mucin, which is an inconvenience. I have cast it aside on that account. Picric acid is a good test, but it unfortunately colors the urine and albumin, which is an inconvenience. It is not so very delicate. I never could do any satisfactory work with Roberts' acidulated brine solution.

Now, in urines where albumin was present only in traces, I have discarded everything except heat and Spiegler's test. This latter was proposed several years ago by a Viennese dermatologist, Spiegler, who, taking advantage of the peculiarity of corrosive sublimate of coagulating albumin, even if present in minute quantities, a characteristic long known, devised a solution of heavy specific gravity, 1060, which I have found a very excellent test for minute quantities of albumin, as, for example, in diagnosing contracted kidney. The formula is :

	Grammes.
Mercuric bichloride,	8.0
Tartaric acid,	4.0
Distilled water,	200.0
Sugar,	20.0

In his first formula, glycerin was added instead of sugar, which was substituted later. Any organic acid will do as well as tartaric, he asserts. This gives a solution which is quite heavy, 1060, and much heavier than any urine, thus making certain a clear and delicate whitish ring at the point of contact. This ring stands out so clearly and distinctly that it is a pleasure to use this test. Yet certain precautions are necessary. If the patient has been taking iodine or the iodides, the yellow iodide of mercury, cheesy yellow in appearance, forms at the ring and masks the reaction of albumin. A little alcohol added will dissolve this and leave the albumin intact. These drugs are, however, rapidly eliminated through the kidneys, and in a few days the reaction will not be disturbed. Mucus must be filtered out before testing.

One must acidulate with acetic acid before testing; otherwise, if phosphates be present, they will deceive one by a decided reaction closely resembling that of albumin. This is not mentioned by Spiegler nor any other writer, curiously enough, but I have noted it time and again. An acid previously added prevents this.

As before said, this test is extremely delicate and reliable. It detects 1 part of albumin in 350,000 parts of urine; but if the solution be old, its delicacy decreases one-half, which is still delicate enough for practical purposes. Care should be taken to drop the urine down the well-tilted tube, that a distinct ring be formed.

Drs. F. Burt and Simmons, of Norwalk, have employed this test solution, and the former especially has come to regard it as worthy of confidence as a working delicate test.

Another point in closing. In these days albuminuria has not the same and serious significance that it had twenty years ago. It must be understood that it does not of itself indicate Bright's disease. Dowse says, from his experience, that out of one hundred cases, in not more than ten (?) is it indicative of Bright's disease. Age, microscopic examination of the urine, and the state of the retinal vessels and arterial tension are all necessary to confirm albuminuria as a sign of Bright's disease. It is often associated with changing periods of life, worry and gout, and want of tone.

He has so qualified his statements that he says much more than it at first appears. I have found from an experience of several years, and from a careful perusal of the urological literature of several languages, that "albuminuria is something that does not breed contempt on closer acquaintance." When I say albuminuria, I mean persistent or intermittent albuminuria. These are both, and especially the former, significant of renal mischief, which sooner or later will be heard from.

Lemoine, in his *Manuel de Thérapeutique Clinique*, p. 330, 1894, states that "in whatever manner the kidney be affected (lésé), it nearly always ends in albuminuria and renal insufficiency. In parenchymatous nephritis it is nearly always the albuminuria, with all its complications, which occupies the foreground; in interstitial nephritis it is, on the contrary, the renal inadequacy."

These qualifying states of Dowse all may and frequently do lead to kidney diseases and associated albuminuria. Albuminuria must be differentiated as to source—leucorrhœa, spermatorrhœa, prostatitis; and, in fact, some writers distinguish one due to affections of the kidneys from one dependent on a disease of the urinary passages.

Persistent albuminuria, I have found, is always to be suspected; and though the general health may seem to be good, the future prospects are not favorable. In short, familiarity with this sign should never breed contempt.

USES OF INTRAVENOUS INJECTIONS OF SALINE FLUIDS.

BY J. W. HASSLER, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society, State of Pennsylvania, Sept. 26, 1899.)

It is the desire of this paper to bring to the attention of this Society the uses of intravenous injections of saline fluids. No subject has received more attention in the past year than injections of artificial serums. Intravenous injections are no more limited to cases of profuse hæmorrhages and shock. There are reports from this country and the European continent relating the experiences for the relief of toxemias, arising from renal diseases, diabetes or any acute infection.

To the surgeons, saline infusions are of common use in shock and collapse. To this list is now added the acute infections.

First, the results obtained in cases of hæmorrhages. If the source of hæmorrhage is where the recourse to hæmostasis by forceps or ligature is an impossibility, as in hæmoptysis, metrorrhagia or intestinal hæmorrhages, intravenous injection of a saline solution acts as the hæmostat. It has been said the use of the salt solution causes an elevation of the blood-pressure, while the decreased blood acts as a hæmostat. This has been proved untenable, as the serum renders the blood more coagulable. Dr. Hayem states this fact: that, for increasing the plasticity of the blood, injections of salt solution act more energetically than transfusion of blood.

In looking over the list of cases as recorded by me, so many present themselves as worthy of report that only two cases have been taken.

CASE I.—Man; disease, typhoid; complication, intestinal hæmorrhages. At intervals for three days he has passed, as the nurses expressed it, a bucketful. I was called at the ending of the third day. The symptoms that presented them-

selves were pale face, temperature 98° per rectum, cold body, pulse quivering and almost imperceptible. Strychnia, one-twentieth of a grain, hypodermatically administered, followed by infusion of three quarts of salt solution. During the injection the pulse gradually reappeared, face partially regained its color, perspiration broke out on the body. In an hour following the injection, temperature 99° , steadily increasing to 101° that evening, pulse full and tension increased, with a slight cerebral excitement. The following morning I was recalled, as the hæmorrhages re-occurred, though not as severe. Pulse weak, temperature not recorded, patient restless. Infused two quarts. The same reaction as previously stated. Beef-tea was given by the mouth. Patient wrapped in flannels, foot of the bed elevated. As reported to me, no reappearance of the hæmorrhages, with recovery in three weeks and two days.

CASE II.—Man; disease, internal injuries. In extreme collapse. Infused, to allow of operation. Upon opening the abdomen a large quantity of free blood was evacuated; upon further examination spleen found to have been lacerated, with only a slight oozing from torn surfaces. Was this partial hæmostasis due to the infusion? Result: case died six hours following.

In cases resulting from shock we have a striking similarity to collapse. In the former a loss of arterial tension due to vasomotor paralysis, produced reflexly by peripheral nerve-irritation, causing a loss of blood from the head and extremities, the blood going to the larger vessels in the abdomen, and there acting feebly. In collapse the blood goes from the body. Therefore, in shock our purpose is to increase arterial tension. If this cannot be accomplished by rest, artificial heat and stimulation, infusion is but the one recourse. Among the number of cases two will be reported.

CASE I.—Female; disease, sarcoma at knee; operation; resection at hip-joint. Temperature prior to operation, 98° ; pulse 136, due to nervousness. During the operation pulse gradually growing weaker and rapid, running at 142, 154 and 164. At the close of the operation, temperature 96° , pulse too rapid to be counted, and exceedingly shallow. Infused four quarts of saline solution. During the administration pulse decreased in rapidity, increased in tension, face regained partially its color: a slight chill, lasting ten minutes. At the end of the first hour, temperature 99° , pulse 136. The second

hour, temperature 102° . Aconite, twenty drops in half a glass of water, one teaspoonful every half hour for six doses, was administered. At the end of two hours the temperature had fallen to 101° , pulse 132 full. Stimulated with milk-punches and broths. Patient made a good recovery.

CASE II.—Boy, age 9; operation, double thigh amputation. Severely shocked. During the operation was infused. Boy made a good recovery. This being an accident case, the temperature and pulse were not recorded prior to the operation. In renal diseases and acute toxemias, artificial serum has given a new lease on life.

The reports from German, French and American authorities are certainly flattering:

CASE I.—Man; disease, parenchymatous nephritis with the following symptoms: partial comatose state; had passed half a pint of urine in forty hours. The hot pack, purging, pilocarpin, with the homœopathic remedy, had failed. Infused two quarts of saline fluid. This was followed by a profuse perspiration, slight chill, and in four hours had passed fourteen ounces of urine. His comatose condition was entirely relieved, and for two days he remained perfectly comfortable, passing a sufficient amount of urine. Eight days following the infusion his previous symptoms returned; the injection was repeated, infusing three quarts, followed by a similar good result, lasting a month. The infusion was again repeated with good results; since then I have heard nothing from the case. Taking the case cited, it seems as if life could be prolonged almost indefinitely, in conjunction with medical treatment.

CASE II.—Woman; disease, septic peritonitis—the peritonitis superinduced, I believe, by dirty instrumentation during curettement of the uterus for abortion. Intravenous injections were given four times in as many days, thereby attenuating the blood—lessening the possibility of toxic infection. Treatment consisted of ice-bags to the abdomen, thorough purging, and a remedy which I have forgotten. Patient recovered.

The treatment of cases by infusion necessitates the kidneys to properly functionate. Atrophic and sclerotic lesions of the kidneys prevent the elimination of urine, resulting in infiltration of the different organs. Perfect antiseptic technique both of instruments and site of operation.

A case was reported to me recently as dying from septic men-

ingitis following an infusion; cause of meningitis attributed to dirty infusing instruments. No air must enter the vein. The French and Germans claim that a small amount of air will be harmless. This seems an error, for it has been demonstrated to me a few times how a small amount of air will produce dangerous symptoms, and even death.

Until a few months ago I had been using the simple salt solution, prepared by adding a drachm of salt to one pint of boiled water—the temperature of the water at 100 degrees F. A number of combinations have been suggested. Dr. Reverdin claims that sodium sulphate has a hæmostatic action, and a number of those interested in infusion use solutions containing sodium chloride and sodium sulphate.

The suggestion of Dr. Locke, of Howard, and Dr. Hare, of Jefferson, seems to be the best at the present day. It is as follows:

Calcium chloride,	0.25 gram.
Potassium chloride,	0.1 “
Sodium chloride,	9.0 “

Sterilized water to make one liter.

It was shown by experiment that the calcium salts are essential to the clotting of blood; also that it will sustain the beats of the heart well and for a long time. But the calcium alone, it was found, caused strong beats which were too prolonged, and, therefore, inefficient; so a small amount of potassium chloride was added to correct the beat.

The preparation has been put up in bottles ready for use by Parke, Davis & Co., thus enabling the practitioner to keep it on hand constantly.

In regard to an infusion apparatus, so many are on the market that it is frequently hard to decide which is the best. Those with stop-cocks or valves are liable to the retention and transmission of air-bubbles. In the writer's hands the syphon method is much preferred—a German-silver V-shaped tube, one leg slightly longer than the other, for use in a large or small pitcher, a rubber tube one yard in length, and a straight canula.

In performing infusion do not forget your antiseptic technique. A vein at the elbow is exposed, preferably the median

basilic. After exposing the vein, place under it, about an inch apart, two catgut ligatures; the distal ligature is then tied, and an opening is made into the vein between the ligatures, and should be made transversely three-fourths through. I have seen a number of failures to enter the vein from the parallel incision. A canula is then inserted into the opening, and is secured in position by tying the proximal ligature. Before the canula is passed the water should be running. In this way all air can be excluded. The rapidity of the flow can be altered at any time, according to the height at which your retaining vessel is placed. The amount the patient should receive is determined by the quality of the pulse and general condition. The amount desired having been administered, remove the canula, ligate the vein, and suture the incision.

TETANUS—REPORT OF A CASE, WITH RECOVERY.

BY WOODWARD D. CARTER, M.D., PHILADELPHIA, PA.

(Read before the Homœopathic Medical Society, State of Pennsylvania, Phila., Sept. 29, 1899.)

THE fact that tetanus, in almost every case, is preceded by a wound of some character has been recognized for many years. But it remained for Nicolaer, in 1884, to demonstrate the presence of the bacillus of tetanus as the specific cause of the disease. This was further confirmed by Kitasato in 1889, who succeeded in obtaining a pure culture.

The bacilli are long, rather slender, having a rounded end, in which is seen a bright round spore. They seldom unite in chains, are non-motile, and have no flagella. They are found in most garden earth, dust and manure, and sometimes in the intestinal discharges of animals.

Owing to the fact that the smallest amount of oxygen will destroy the growth of the bacillus, it has been very hard to cultivate. The following method, originated by Kitasato, is now universally employed. He exposed the material to be investigated to a temperature of 80° C. for an hour. This destroyed the majority of spores except tetanus, making their cultivation in gelatin or agar-agar a matter easy of accomplishment.

The tetanus toxin is prepared by growing the bacilli in bouillon, the culture medium being kept at a temperature of 37° C., and allowed to remain from two to four weeks. By this time it will have gained sufficient strength. It is easily destroyed by heat or light, so that a cool, dark place is necessary to preserve it.

The gradual introduction of this toxin into the blood of animals enabled Behring to produce the antitoxic serum of tetanus.

The results obtained from the use of serum in the treatment of this dread malady in man have been somewhat disappointing. Extensive experimentation, however, has shown that the investigations have been conducted in the right direction.

Tizzoni claims that the usual mortality-rate is 80 per cent. Up to 1898 he had collected 114 cases treated with antitoxin, which gave a mortality death-rate of 46 per cent. But eliminating a large number which appeared after a long period of incubation, as well as those which were only of mild form, he found that 38.7 per cent. of the acute severe cases recovered, as compared with 20 per cent. under the old-line treatment.

He calls attention to the fact that it takes 24 hours for complete saturation of the system with antitoxin. In cases, therefore, which are of rapid onset and short duration, antitoxin can be of no benefit. He advises, therefore, preventive inoculations of antitoxin in man and animals with dirt-laden wounds. This recommendation is based upon Roux's statement that the toxin can be readily neutralized at the time of infection. But a short time after, it requires doses thousands of times larger to accomplish the same result.

Lanphear (*American Journal of Surgery and Gynecology*, July, 1899) has personally collected reports of 38 cases from Iowa, Missouri and Illinois, of which 20 died and 18 recovered—a mortality of 52 per cent. He also gives reports collected from various sources, *e.g.*: W. E. Green, Great Britain, reports 36 cases treated with serum, with 25 recoveries. R. F. Wier, New York, 11 cases, with 9 recoveries. Haddeus, Germany, says that "tetanus antitoxin should be given in every case, as it is a specific if given soon after the appearance of the toxic

symptoms." C. L. Fraser (in the *London Lancet*, August 26, 1899) reports a case with recovery. Dr. W. M. James, New York, successfully treated a case of tetanus with antitoxin. He remarks that he has seen 30 cases of tetanus, with fatal results in every case until this last experience (*N. Y. Medical Record*, September 9, 1899).

A series of experiments have recently been published by Roux and Borrell (*Annals de l'Institut Pasteur*, April, 1898). A portion of the brain substance of a guinea-pig was crushed and mixed with some tetanic toxin, and the mixture centrifugalized. This separated into two layers, the upper an opalescent fluid, the lower the nervous substance. The lower layer contained the tetanic toxin, while the upper had comparatively none.

From this they argued that tetanic toxin, finding its way into the organism, is appropriated by the nerve-cells.

Marie has pointed out that the poison reaches the nerve-centres by two routes—a part follows the course of the nerves and is fixed by the cells of the spinal cord; another portion of the poison enters the blood, whence it is extracted by the nerve-cells. Thus the cells of the cerebrum can be affected by the toxin brought to them through the circulation.

Furthermore, Roux and Borrell found that when toxin was injected directly into the brain of guinea-pigs, the dose required to cause tetanus was much smaller than when a subcutaneous injection was made. "Cerebral tetanus" results from the former owing to the nearly immediate fixation of the tetanic poison, and the symptoms are excitement, intermittent convulsive attacks, motor disturbances and polyuria.

From these experiments the authors drew the following conclusions: "The tetanic antitoxin, when injected into animals, remains in the blood, whereas the toxin is extracted from it and fixed by the nerve-cells. The antidote does not come in contact with the poison, and the two substances, though so near each other, fail to meet. The serum is efficacious against toxin which is placed under the skin because the greater part of it enters the blood, but it proves powerless against the poison which has already reached the nervous elements." To overcome this difficulty and enable the antitoxin to spread by direct continuity of nerve structure, the authors trephined and injected the antitoxin into the brain substance.

Geo. C. Rambaud, M.D. (*New York Medical Journal*, Dec. 17, 1898), makes report of their experiments thus: "They treated with intracerebral injections of antitoxin 45 tetanized guinea-pigs; 35 of them recovered. Seventeen others were treated with subcutaneous injections; only 2 of them survived. Seventeen guinea-pigs were not treated with the serum; all died. Theory and experimentation agreed. Antitoxin introduced into the brain protects the upper part of the cord when the lower portion is already affected by the poison, but it does not cure the lesions that have already taken place. The contractions existing at the time of intervention persist for some time; and Roux and Borrell state that, if the medulla is already poisoned (shown by impaired deglutition, and possibly respiratory disturbances), death cannot be prevented.

"After the excellent results obtained in animals, it remained to try the experiment in man. It might be objected that the risks incurred are numerous; but since it is the only chance the patient has, he should receive the benefit of it.

"However, after some consideration, it can be seen that the risks are really trivial. If the intracerebral injection is made in a neutral area, such as the fore part of the frontal lobes, the result of the trauma is minimized; the injury caused by the small hypodermic needle is trifling; the quantity of serum injected is comparatively small, and, being introduced slowly, no undue compression is caused; hæmorrhage from the dura and pia are easily avoided; the button of bone removed being small, healing of bone takes place rapidly, and no subsequent adhesions leading to irritation are likely to occur.

"It must be added that, notwithstanding the intracerebral injection, it is necessary for obvious reasons to continue to give antitoxin intravenously or subcutaneously for a few days; the toxin in circulation with the blood, together with that which continues to be secreted at the site of the injury, is thereby neutralized and cannot affect the nervous centres."

Dr. Rambaud, in the same article, reports a series of 11 cases, 3 of which came under his own observation, and the rest were collected from abroad. All of these were treated with the combined method, *i.e.*, serum injected into the cerebrum and subcutaneously. Of these cases, 5 recovered.

Dr. Lanphear has also collected a series of 11 cases, mak-

ing a total of 22 operations for intracerebral injection of serum, with 13 deaths and 9 recoveries—a death-rate of 59 per cent. In the following case the subcutaneous injections were wholly used, although the hospital facilities were offered by Dr. Van Lennep for the intracerebral injection. But the patient improved so rapidly under the subcutaneous injections that the latter method was not thought necessary.

W. T. F., 13 years. On January 11, 1899, was hit with a piece of ice on the left side of the lower jaw near the angle, the resulting injury being a lacerated and punctured wound. This was washed with Castile soap and covered with court-plaster. In two days the wound was apparently healed.

Three days from the inception of the wound, swelling and hardness appeared at the seat of injury and caused considerable pain. The mother poulticed this with flaxseed.

From January 15th to 27th there was marked stiffness of the jaws with tonic spasm of the left side of the face, together with pain in the neck, jaws and shoulders. Sudden twitching of muscles occurred, with some rigidity of muscles of the entire body, particularly the dorsal groups. On January 27th I was called to see the case. The parents reported that during the night the patient was awakened from sleep with a series of violent tonic contractions of muscles of the whole body. This lasted for 20 minutes; the patient became cyanotic and lost consciousness, from which he recovered after the expectoration of quantities of bloody mucus.

Upon examination, the following conditions were evidenced: Jaws were tightly locked; the muscles of the face had assumed the characteristic picture described as risus sardonius. The neck-muscles were perfectly rigid, as were those of the back and abdomen. The legs and arms were lax.

Dr. W. D. Bayley was called in consultation in the afternoon of the same day. The same conditions prevailed, excepting that the leg-muscles were rigidly contracted, so that the patient, while perfectly conscious, could have been actually raised by his feet, like a board, and stood on his head.

The temperature was normal; pulse 80.

The subcutaneous injection of antitetanic serum was advised. Twenty c.c. was at once injected into the chest-muscles.

January 28.—The patient had three general tonic spasms,

the position of opisthotonos being assumed. Each spasm was followed with great prostration. Slept about five minutes at a time at twenty-minute intervals. General clonic jerking of groups of muscles. Thirty c.c. of serum was injected.

January 29.—During the night had one tonic spasm, but clonic spasms continued as before. Leg-muscles more lax. Slept fifteen or twenty minutes at a time. Temperature 101°; pulse 100. Bowels moved by enema. Took nourishment through a tube. Injection 20 c.c. of serum.

January 30.—Injection 20 c.c. of serum. Slight improvement. Temperature 99°; pulse 80.

January 31.—Injection 20 c.c. of serum. Temperature normal; pulse 80. No tonic spasms. Could open the jaw far enough to drink nourishment from a cup.

February 1.—Injection 20 c.c. of serum.

February 2.—Injection 20 c.c. of serum.

February 3.—Injection 20 c.c. of serum. At the seat of each needle-puncture a diffuse erythema appeared.

February 4.—Erythema increased. Could open jaws three-quarters of an inch. Formed bowel movement passed normally. Injection 20 c.c. of serum.

February 5.—Muscles more relaxed. No clonic spasms. Three watery bowel movements. Erythema appearing over all portions of the body. Serum injected, 10 c.c.

February 6.—Complained of intense headache. The rash not so marked. The use of serum was discontinued. *R.* Hyoscy. θ in water.

February 7.—Headache continues. Temperature 101°; pulse 120. *R.* Hyoscy. θ .

February 8 to 11.—No change whatever.

February 12.—Improvement. Temperature 100°; pulse 88. *R.* Continued.

February 13.—Diarrhœa, green watery stools. *R.* Bell.

February 14 to March 3.—Gradual improvement. Jaw slowly relaxed until March 10th, when patient was discharged completely recovered.

In conclusion, I would call your attention to the following points in the case:

1. The period of incubation was three days.
2. The first injection of serum was given sixteen days after the injury.

3. The prompt improvement in the symptoms following the first injection of serum. The total quantity of serum used was 200 c.c.

4. The diarrhœa and rise of temperature which occurred on February 7th. The cause of this was attributed to the use of the serum. Believing that in this case the physiological limit had been reached, the serum was discontinued, followed by an abatement of the symptoms.

5. The patient's appetite at no time failed him. He was ravenously hungry, and would take great quantities of liquid, and later solid, nourishment.

6. The appearance of the erythema spreading from the seat of the injection until it became almost universal. I was unable to determine the cause of this, attributing it either to the lysol, which was used as a disinfectant, or to the serum. A discontinuance of the lysol solved this question, since the rash appeared at the seat of each subsequent needle-puncture as it had before, when the lysol was being used.

TREATMENT OF TYPHOID FEVER.

BY GEORGE B. PECK, M.D., PROVIDENCE, R. I.

(Read before the American Institute of Homœopathy, Atlantic City, N. J., June 24, 1899.)

THE following statement concerning the management of persons whose systems the typhoid bacillus is ravaging is based upon reports consecutively received from 250 members of the American Institute of Homœopathy residing in most of the States and Territories from Maine to Alaska and Canada to Florida, including those several localities. Reports from Drs. Oscar Hansen, of Copenhagen, Theodore Kafka, of Carlsbad, and Frederic Delosea, of Frankfort, are also counted in therewith.

In every thousand prescriptions made for an ordinary case of enteric fever, at least 202 are for bryonia, 176 for baptisia, 172 for rhus toxicodendron, 121 for arsenicum album, 78 for gelsemium, 53 for belladonna, 16 for hyoseyamus, 12 each for aconitum napellus and mercurius, 11 for phosphorus, 9 for

phosphoricum acidum, 6 for mercurius solubilis, 5 each for arnica, china, ferrum phosphoricum, kali phosphoricum, lachesis, muriaticum acidum, nux vomica, sulphur, terebinthina and veratrum viride; 4 for kali muriaticum, 3 each for mercurius corrosivus, opium and pulsatilla; 2 each for apis, ipecacuanha, lycopodium, nitricum acidum and stramonium; 1 each for arsenicum iodatum, arum triphyllum, calcarea carbonica, carbo vegetabilis, chamomilla, croton tiglium, cuprum arsenicum, eucalyptus, guaiacol, ignatia, kali sulphuricum, mercurius iodatus flavus, natrum muriaticum, natrum sulphuricum, psorinum, pyrogenium (?) and secale cornutum.

When manifestations of cerebral disturbance are unusually prominent, in every thousand prescriptions hyoseyamus will be administered at least 182 times, belladonna 179 times, stramonium 72, baptisia 46, rhus toxicodendron 44, gelsemium 43, bryonia 40, opium 31, helleborus niger 16, agaricus muscarius 10, arsenicum album and hyoscine hydrobromate, each 9; phosphoricum acidum 8, veratrum viride 7, kali phosphoricum and lachesis, each 6; apis, arnica, phosphorus and zincum, each 5; coffea 4, aconitum napellus, agaricin, ferrum phosphoricum, glonoin, muriaticum acidum and passiflora incarnata, each 3; atropinum, cicuta virosa, cimicifuga and cocculus, each 2; arum triphyllum, chinium arsenicosum, conium, cuprum aceticum, hyoscine undesignated, ignatia, magnesias phosphorica, morphinum, nux vomica, petroleum, phenacetin, potassium bromide, strychninum, veratrum undesignated, and zinc oxide, each 1.

When the diarrhœic symptoms are the more pronounced, in each thousand prescriptions it will be found that arsenicum album has been written for at least 170 times, rhus toxicodendron 101, phosphoricum acidum 48, mercurius corrosivus 37, baptisia 36, mercurius 29, china 26, muriaticum acidum 25, bryonia 24, podophyllum 22, nitricum acidum 17, veratrum album 16, mercurius solubilis 14, cuprum arsenicosum and phosphorus, each 13; carbo vegetabilis 12, sulphur and terebinthina, each 10; ipecacuanha 8, arnica 6, aloë, hyoseyamus and kali phosphoricum, each 5; nux vomica and pulsatilla, each 4; lachesis, 3; arsenicum iodatum, calcarea phosphorica, cantharis, chamomilla, colchicum, croton tiglium, echinacea, eucalyptus, gelsemium, gummi gutta, kali muriaticum, leptandra, opium, sulphuricum acidum and veratrum viride, each 2; apis,

belladonna, bismuth, bismuth subgallate, calcarea carbonica, calcarea sulphurica, camphora, cantharis, colocynthis, cuprum, euonymin, ferrum, ferrum aceticum, geranium maculatum, guaco, hamamelis, jatropha curcas, kali arsenicosum, lycopodium, magnesia phosphorica, mercurius cyanatus, "mineral acids," morphinum, natrum sulphuricum, salol, secale cornutum, sweet oil, zincum, zinc sulpho-carbolate, and a combination tablet of morphinum 2x and mercurius solubilis 2x, each by 1. One correspondent remarked, "I so seldom get diarrhœa I can hardly say what I give."

For the relief of intestinal hæmorrhage, in every thousand prescriptions it will be found that the following drugs have been selected, at least: Hamamelis 116 times, nitricum acidum, 97, terebinthina 62, ipecacuanha 40, secale cornutum 38, china 36, muriaticum acidum 23, phosphorus 19, arsenicum album 17, geranium maculatum 12, erigeron and phosphoricum acidum, each 10; carbo vegetabilis and millefolium, each 8; ferrum phosphoricum, lachesis, mercurius corrosivus and rhus toxicodendron, each 7; arnica and gallicum acidum, each 6; aconitum napellus, belladonna and hydrastis, each 4; morphinum and sulphuricum acidum, each 3; cinnamomum, crocus, ferrum aceticum, gelsemium, kali phosphoricum, thlaspi bursa pastoris and trillium pendulum, each 2; alum (?), alumen, alumina, apis, argentum nitricum, baptisia, bismuth subnitras, bryonia, camphora, cantharis, chininum arsenicosum, ergotole, eucalyptus, ferri sulphas, guaiacum, hydrastine hydrochlorate, lemon juice, melilotus, mercurius, mercurius cyanatus, mercurius solubilis, "mineral acids," naja, natrum muriaticum, nitromuriatic acid, opium, phosphomuriate of quinine, plumbum, rhus aromatica, sepia, sulphur, tannin, tinctura ferri, veratrum album and veratrum viride, each 1. One correspondent remarks he has no special remedies. No true homœopath has, but he prescribes one drug oftener than another, as the merest glance at his medicine-closet would demonstrate.

Adjuvant treatment for the relief of intestinal hæmorrhage is *not* resorted to by 103 of my correspondents; 26 left the appropriate space for reply *blank*, which legitimizes the conclusion that their habit is similar; 3 rarely employ such measures, while 108 responded affirmatively. The devices of these are numerous, some mentioning a number. Enemata of witch

hazel are used by 15, turpentine stupes by 13, ice-bags by 12, one of whom intimated he had forsaken the habit; "cold to abdomen" by as many, though one failed to see any benefit from it; morphine by 10, "cold compresses" by 8, the cold pack by 6, enemata of hot water and of dilute nitric acid each by 5, of starch-water by as many (one of whom adds, however, a little hamamelis), and starch with some preparation of opium by an equal number; intravenous injections of normal-salt solution by 4; enemata of normal-salt solution, cold enemata, compresses of hamamelis and water, which in one case, at least, was cold, ice-coil to abdomen, ice over abdomen, and ice-pack each by 3; enemata of tannic acid, of geranium, of turpentine and hot water, and of unspecified material, hot compresses, cool compresses, cold sponging, normal-salt solution hypodermically, ice over the right iliac fossa, hot water and chips of ice each by 2; enemata of ice-water, of lemon-juice and ice-water, of phosphoric acid and water, of slippery-elm water, of chloroform, of hot water, of hot water and boracic acid, of "oil, milk and witch hazel," of hot salt water, of erigeron solution, of sweet oil, of hot antiseptics, of warm undesignated substance, warm fomentations, hot sponge bath, tepid applications, ice-water compress, ice poultice (mixed with bran), ice per rectum, ice internally and externally, abdominal compresses, compress of calendula, compress of cajuput oil and alcohol, cold alcohol and water compresses, cold compresses of vinegar and water, "turpentine and alcohol externally," turpentine internally, slippery-elm tea, astringents, ferri sulphas, acidum gallicum, opiates, cold drinks, hot drinks, ergotole hypodermically, "ergot injected into the bowels," "ergotine," suppository of tannin and morphia, flushing the colon, antiphlogiston plaster, "cold pack and infusion of normal-salt solution" (which saved the patient for a time, but death ensued from weakness), opium and lead, one pint of hot water with a few drops of turpentine or a teaspoonful of hamamelis (mode of administration unspecified) each by 1. Single correspondents remark as follows: Have never had this complication in a case treated from its commencement; intravenous saline injections discarded within a year for subcutaneous injections; "suppositories of tannin and morphia, with a compress of cold alcohol rather tight across the bowels. It don't generally check, though, if

the case is bad enough for hæmorrhage, it will die; if not from that, then from some other complication."

But three instances of operation for the relief of perforation were reported. In one case the peritonæum was twice washed, but death ensued. The second was reported by Edward R. Snader, M.D., of Philadelphia, as follows: "Some years ago I saw, in consultation, a case of perforation of the bowel during the second week of typhoid fever, which I advised to be operated upon. It was an exceedingly mild case, so much so as to be somewhat obscure in diagnosis; that is, so far as the determining cause of the perforation was concerned. It seemed possible that the case might really be an obscure, suddenly-perforating appendicitis. The condition of the patient prior to operation was most favorable, the case having run an almost afebrile course, the heart strong, and the patient, an adult male, naturally robust. Death seemed inevitable without surgery, and I therefore recommended abdominal section. I believe I was thus the first in this country to recommend operation for perforation; at least, I had never heard, read nor dreamed of the operation for that purpose prior to that time. At the section was found a perforation that would easily have admitted the end of a lead-pencil—an extensively-ulcerated Peyer's patch. Engorged Peyer's glands could be plainly seen through the mucous membrane, and some appeared so thin that they, too, seemed ready to burst. From the operation proper the patient made a good recovery, but he perished two weeks later from sudden, overwhelming cardiac failure, with high temperature, maniacal delirium and vomiting. These symptoms, when later heard of (for I retired after the operation, and the allopathic surgeon attended the case), I believed to have been due to a septic pericarditis, with effusion, and possibly another surgical procedure might have saved the patient's life. This occurred before the operation had come to be spoken of as a rational procedure in cases of perforation. In the same kind of a case, *i.e.*, one in which the typhoid state was not pronounced, I should unhesitatingly recommend the opening of the abdomen and the closing of the perforation; but in the presence of marked tissue degeneration I should oppose the operation as being worse than useless. The case was not reported because of its fatal termination, I presume; at any

rate, I did not feel like making the case public because it was not my own. The surgeon who did the operation, and who examined the wound prior to the end, to ascertain if a septic peritonitis was the cause of the severe symptoms, stated that the opening caused by the operation was healed, and there was nothing whatever in the abdomen to account for the serious condition of affairs at the close of the patient's life. The case, so far as the operation was concerned, was a success, although the patient died, but not from the perforation nor the operation." A third was reported by a gentleman who, practicing surgery almost exclusively, has met but one case officially in the last five years. This was diagnosed appendicitis, and he operated. On opening the peritonæum, a portion of the intestine came into view, with round, purplish thickening. He replaced that at once, and drew forth another portion, with more round thickenings (Peyer's patches?). He decided the case was typhoid fever, and would have sewed up the wound, but that the symptoms were decidedly those of appendicitis. After hesitating a few seconds, he decided that a careful examination of the appendix would do no more harm than had already been wrought. He found it swollen, purplish, evidently diseased, and bound with new adhesions. He removed the appendix, and found the mucosa destroyed, the organ dilated and full of pus and gangrenous detritus. The patient died on the second day, with unquestionable indications of typhoid perforation and shock. Conclusions: The patient was in a fair way to die of appendicitis, if not also of typhoid fever; did not the ether, shock of operation, etc., lower vitality so much as to cause fatal perforation? Is operative interference ever justifiable in typhoid? One correspondent remarked he had not witnessed a perforation during twenty-seven years of practice; others made corresponding statements covering various periods of time.

Two hundred and sixteen practitioners are accustomed to order milk for their typhoid patients, but quite a number of them prefix the adjectives hot, cold, sterilized, peptonized, salted, etc.; 61 malted milk, 43 beef broth, 33 mutton broth, 27 broths, 23 liquid diet, 21 buttermilk, 17 grape juice, 15 bovine, as many rice water, and still an equal number beef juice, 12 liquid peptonoids, 11 koumiss, and as many beef extracts, 10

barley water, and an equal number fruit juices, 9 chicken broth, and as many ice cream, one of whom specifies vanilla, groups of 8 beef peptonoids, orange juice, light soups, imperial granum, rice, egg albumin with water and a milk diet respectively; groups of 7 panopeptone, whey and milk with lime water; 6 Eskay's food; groups of 5 lamb broth, watermelon, Mellin's food, egg-nog, oatmeal gruel (some specify strained), and hot water with sweet cream occasionally (though one of these directs the water shall *not* be hot); groups of 4 raw eggs, lemonade, soft boiled eggs, broth and toast water; various triplets matzoon, junket, fruit, tea, gelatin, orangeade, lime water, custard and "rarely milk;" sundry couples flour gruel, ginger ale, milk and Vichy, milk with lime water and egg albumin, no milk, blanc-mange, sago, tapioca, cocoa, coffee, crust coffee, Horlick's food, clam broth, grapes, lemon juice, no beef tea and no solid food for eight days after the fever; single practitioners hot water, boiled water, milking, artificial milk foods, clabber, crackers, rice gruel, cornmeal gruel, proprietary baby foods, farinaceous diet if possible, somatose, protonuclein, calf-foot jelly, white of egg and milk, eggs, bovine with grape juice, lime juice, cereal coffee, wheat tea, sour cider, Zwiebach, blackberries, peaches, baked apples if no diarrhœa, baked apples anyway, blackberry juice, pea soup, gum arabic water, no beef extracts, no fruit juices, no tea, no coffee, principal diet cracked ice and water, "nothing but pure cold water and nothing else," no ice water or cracked ice, cold water only for three or four days, and real bone soup if constipated. Some direct that the drinking-water be sterilized, some do not urge nourishment at the beginning, and some direct very little food of any kind as long as there is fever. The minimum time allowed to elapse between feedings one hour by 2 practitioners, two hours by 72, three hours by 68, four hours by 12, six hours by 1, and eight hours by 2. One says "feed sparingly," another "little and often," and a third "not too often nor too much." One doctor reports "baked white potato and buttermilk was the only diet in two cases that did well; one had experienced a slight hæmorrhage before coming under my care; nothing seemed to agree with his stomach, potato was craved and allowed, the patient began to improve and remarked, 'I tell you, doctor, there is nothing like potato for an Irishman.'"

Alcohol is *not* administered internally to typhoid fever patients by 100 of my correspondents, *rarely* by 93, and more frequently by 55. One gentleman remarked he gave it once and has ever since regretted it, another that he gave the murderous stuff for thirteen years while practicing allopathy, and a third that in no disease is alcohol more strongly contraindicated unless it be in cholera infantum. Whiskey is prescribed by 56, brandy by 52, egg-nog by 15, milk-punch by 11, champagne by 7, wine, claret and "whiskey and milk," each by 3; alcohol in milk, port wine, hot sling, whey and alcohol, each by 2; sherry, "mild wines," blackberry brandy (in white of egg and water), brandy and milk, ale, only in form of wine whey, California catawba wine, and "rum and milk if the respiratory organs are involved," each by 1. An indication for the use of stimulants is stated to be cardiac weakness by 40, collapse by 31, extreme prostration by 17, general weakness by 15, turn of fever by 14, convalescence by 6, excessive delirium, gastric irritability and after hæmorrhage each by 2; severe diarrhœa, sub-normal temperature, hyperpyrexia, insomnia, and to prevent undue waste of tissue each by 1.

Sponge baths are recommended by 228 practitioners, rarely by 7, and not at all by an equal number. One doctor naively admits he occasionally permits one for cleanliness. Tepid water is ordered by 53, alcohol and water by 45 (one specifying it shall be 85°, two 98°, a fourth hot, a fifth cold, a sixth tepid, and a seventh warm), water and bicarbonate of soda by 26 (four saying it shall be hot, as many warm, and one cold), cool water by 24, hot water by 19 (one following it with an alcohol rub), cold water by 15, cider vinegar and water by 9, a cold saline bath by 5, aqua ammonia and water by 4, one of whom says it must be hot, soap and water also by 4, one following it with alcohol and water half and half, water 100° again by 4, a cool saline bath and an alcohol rub, each by 3; ice water, warm salt and water, hot alcohol sponge full strength, alcohol sponge at night and water between 60° and 70° F. (one adding ammonia), each by 2; an alcohol sponge twice a day, quinine water, hyposulphite of soda and water, lukewarm water, hamamelis and alcohol, warm water and aromatic vinegar, alcohol with salt and temperate water, and hot normal salt solution, each by 1. Some merely indicated preferred temperature: thus 24 sim-

ply say warm, 15 as desired, 5 as cool as the patient will allow, 3 temperature of the body, 1 each "100°," dropping down to 88°," and "lukewarm, reducing to ice water." One doctor directs the water to be of agreeable temperature, and it must not be wiped off, but allowed to evaporate—this to be repeated at frequent intervals, even every hour, and lasting from ten to twenty-five minutes. High temperature is deemed sufficient indication by 34, cleanliness and comfort by 29, extreme restlessness by 22, a temperature of 102° F. by 14, a temperature over 103° by 11, when the fever is the highest by 10, a dry skin by 3, a dry and hot skin, insomnia, delirium, copious perspiration and a desire to keep the temperature down, each by 1. One doctor bathes with ice-cold water and alcohol when the temperature reaches 104°. As to repetition, 36 order them frequently, 33 daily, 12 every two to four hours, 11 twice a day, as many from two to four times a day, 10 every three hours, 9 every two hours, 5 every three to six hours, as many every three to four, 4 two to six baths daily, as many night and morning, and again as many only at night; couples respectively every six hours, sometimes every hour, three times a day, and every hour when the temperature is 104°; a solitary doctor one every third day.

Tub baths are *never* ordered for typhoid patients by 225 practitioners, rarely by 12, occasionally by 3, and quite frequently by 10. One uses them for children only, another for restlessness; two to reduce the temperature and three for high temperature, one of whom says the water must be at 80°, and another that it shall be "lukewarm, decreasing to cold." One orders immersion in cool water for ten minutes if the temperature goes above 104½°; another says that for a temperature of 103° the bath shall be one degree lower; while a third, when he finds a fever of 103°, commences with water at that temperature but reduces it to 77°. Referring to the temperature of the bath, only two practitioners say it should be as hot as can be borne, as many that it should be 100°, and single physicians "uncomfortably cool," agreeably cool, tepid, 76°, 80° cooling down to 60°, and "a few degrees below that of the body" respectively. One doctor orders a tub bath daily until the patient gets so weak it seems to exhaust him.

As to very cold or iced water and ice, 202 physicians state they do not use them. One of these significantly added, "I

have, however." It is to be presumed he became wiser through sad experience. Another declares, "Ice and very cold water are pernicious." A third reports that once he indulged in this sort of thing by means of a wet sheet for a temperature of 108° , other bed-coverings having been removed. The temperature was reduced and the patient apparently convalesced for a few days, when perforation and death ensued. A fourth says he practices in the country, and if a case should die "they would think I killed him, and I, myself, might feel a little guilty." A fifth uses "iced water by direct application if the patient does not or is too stupid to protest!" A sixth remarks, "Heat to heat and cold to cold is the only homœopathic law of cure." More generally 12 use the cold pack, 6 cold water compresses, 5 the ice cap, as many the ice-water pack, 4 the rubber coil on abdomen, as many ice-cold applications to the head (one adding the body also), 3 ice-water compresses, as many cracked ice in rubber bags or tubes, and 2 in tubes only; single practitioners ice bags on head and neck, cold sponge-baths frequently repeated, cold half pack every three minutes for twenty minutes, cold saline pack, ice pack, cold compresses, cold water on wrists, and cold water on chest and hands. One remarks that he has used the ice coil to a limited extent but is doubtful as to its efficacy. As for indication, 1 finds it in a bloated condition, another in a temperature of 105° , 2 in 104° , 2 in 102° and 2 in a "high temperature."

Enemata are not ordered by 56, rarely by 48, occasionally by 5, more or less habitually by 140, while one acknowledges he did thus use beef tea for a few days but it did more harm than good. As for their purpose, "to empty the lower bowel" is specified by 76, great constipation by 56, for nourishment by 16, for diarrhœa by 5, for tympanitis and to soothe the bowel, each by 4; to reduce the temperature by 3, to allay pain and for cleanliness, each by 2; to relieve constipation of forty-eight hours, to reduce thirst, to please the friends, for flatulence, and for nervousness with restlessness and diarrhœa, 1 each. As to material, 56 use warm water, 16 soap and water, 9 glycerin and water, 8 hot saline solution, one of whom adds the words "for collapse;" 7 hot water, 6 salt and water, one of whom directs it to be cool and another cold; 6 normal salt solution, one ordering it warm; 6 turpentine enemata for carrying off gas, 4

warm water and olive oil, 4 warm water and starch (into which two also pour laudanum) for diarrhœa, groups of 3 each respectively cool water, milk, flaxseed water, flaxseed tea, hot water containing boracic acid, peptonized milk (to which two add bovinine); couples respectively molasses and water, beef extracts, milk and egg, beef broth and olive oil followed by water; single practitioners "starch and laudanum to relieve tenesmus," "starch for tenesmus," "starch water for irritation," ice water, creolin enema, milk and water with bovinine, cold water, glycerin suppositories, turpentine, albuminized water for constipation, slightly carbolized water, whiskey and egg albumin, milk with egg and whiskey, warm water with milk and salt or chicken broth, olive or sweet or cotton-seed oil, yolk of eggs with turpentine for tympanitis, hot antiseptic enema, "slightly antiseptic to clear the lower bowel," "either water or milk to maintain vascular supply, and for nourishment egg with milk and starch." One doctor says enemata are dangerous after the first week, another orders them every three days, still another daily, while a fourth determines whether they shall be hot or cold by the temperature of the body.

The colon is *not flushed* by 187 of my correspondents, one of whom remarked, "There never is an indication to flush the colon, because the colon is not an old piece of rubber tubing or a sewer pipe. I treat my patients as if they were delicate complex physiological organisms." It is flushed *rarely* by 26, and more or less habitually by 37, one of whom states he does it only when first called to a case. Hot water is used by 10 (by one "medicated"), warm water by 5, normal salt solution when patient is very low by 2; cool water, turpentine and water, boracic acid solution, warm water and glycerin each by 1. High temperature is considered an indication by 6, one of whom adds "in the early stage;" severe diarrhœa by 4 (one of whom says the water must be from 95° to 100°), severe tympanitis also by 4, offensive stools by 3, temperature over 103° by 2 (one of whom uses tepid water, the other cold water, beginning at 40° and reducing it to 30°); hæmorrhage also by 2; three or more dejections, yellow-ochre stools which are frequent and painful, constipation, delirium, a temperature of 104° long continued, a "temperature stationary despite the indicated remedy," each by 1. Furthermore, 1 flushes every

twenty-four hours, 1 every twelve hours, 1 to stimulate the kidneys, and 1 in last stages when there is danger from hardened feces. Finally, 1 simply states he uses water from 80° to 90°; another resorts to flushing during the first week only, and then with normal salt solution or sterile water, while another always orders it unless it be contraindicated by intestinal hæmorrhage.

Intestinal antiseptics is not practiced by 206 of my correspondents, one of whom declares "there is no such thing," and another, quite as emphatically, "it can't be did!" It is attempted rarely by 17, and quite generally by 23. To secure this condition listerine is administered by 5, one of whom specifies it as an enema: salol also by 5, antiseptic enemata by 3, one saying they must be hot; solution of boracic acid also by 3, two using it per rectum; guaiacol, the Woodbridge treatment, and pix cresol tablets with hot water each by 2; pix cresol by mouth, pix cresol 3x, echinacea or listerine by mouth, turpentine, iodoform 3x internally, hydrogen peroxide, eucalyptus, eucalyptol, ox-gall solution, enema of water containing a little hydrogen peroxide, drinking-water containing a little hydrogen peroxide, phenol sodique enemata, borax solution, formalin enemata, Harvey's typhoid tablet No. 2 every four hours, zinc carbolate, borolyptol, "eucalyptus tincture for putrid cases, douches, etc.," enemata of pasturine, hydrogen peroxide or listerine enemata rarely, each by 1. Sulpho-carbolate of zinc is used by 3, one giving diarrhœa as its indication, tablets containing the sulpho-carbolates of calcium, sodium and zinc by 2, and hydrozone also by 2, one specifying pus in the stool as its indication.

Most of my correspondents have insisted upon the importance of rest and quietude. Precisely how tub-baths and assorted "packs" contribute thereto I am unable to comprehend. Electricity is recommended "if the nervous system is in a bad, low condition." Three were found who, when called early, evacuate the bowels with some cathartic to clear them of any food-waste they might contain and which by fermentation might cause trouble. One "almost literally pours water into the patient, giving him quarts during the day." Another washes the mouth, when foul, with listerine, hydrogen peroxide, zymocide, or borolyptol. A third exhibits in the beginning refined

sulphur to light physiological action. A fourth, for tympanitic condition, uses a cotton pack wet with whiskey and sprinkled with common salt. A fifth occasionally applies dry heat to the abdomen. A sixth generally uses corn sweats every day or two, each one lasting an hour. A seventh always gives protonuclein, grs. ix, every three hours until the temperature is below 102° , afterward grs. iij every six hours. An eighth always keeps warm water and aromatic vinegar on the wrists and abdomen. An ex-president has found imported ginger very acceptable and beneficial in recent cases. One of us common doctors sometimes uses a cold-water rubber bag to relieve restlessness. Another, after the fever has gone, permits little children well enough to beg for food to eat one or two wintergreen lozenges a day. A third, in desperate cases, resorts to psorinum.

The method of treatment pursued by one correspondent not included in the 250 is so unique, as is also his statement of alleged facts, I venture to give his reply quite in detail. "Total abstinence from food until the fever subsides; repeated large warm-water enemas, frequent tepid baths. Have never observed cerebral symptoms after that treatment. Large enemas to thoroughly cleanse the bowels; diarrhœa shows an effort to rid the bowels of offensive matter." In reply to the query concerning relief of intestinal hæmorrhage, he says: "Hot fomentations over the lumbar region, the surface of the body being carefully warmed, and especially the feet," but he immediately adds, he "never had any sequæ. No feeding at all. One case last summer was substantially without food for five weeks. Did not lose much flesh. Entire recovery. Tried two or three times to feed him, but always caused return of fever until the last time. Never uses alcohols internally or externally, nor puts drugs in the bathing water. Tub baths of 90° of five minutes duration may be repeated daily, but not oftener as a rule." His reason for extensive use of enemata is, "a filthy colon and an obstructed canal are the chief conditions for typhoid. The presence of this disorder is sufficient indication for flushing the colon at 100° . I occasionally dissolve a little boracic acid in the enemas. Rest, perfect cleanliness and abstinence from food in order to secure the rest has proved all-sufficient in my hands."

I have omitted statements relative to the success of treatment employed, tendered by quite a number of my correspondents, but they will be utilized elsewhere. The methods above summarized, however, will be pronounced by each reader good, indifferent and bad according to his bias. Note, however, that in thirteen cities, during the years 1890-95, allopathic practitioners reported 14,313 cases, with 3229 deaths, or a mortality of 22.56 per cent.; while in the same cities during the same periods of time the alleged homœopaths treated 2082 cases and lost 334, or 16.05 per cent. While this indicates the saving of six additional lives in every hundred cases, and sixty-five in every thousand, I can but consider the margin discreditably small, and venture to suggest that if we all devoted more time and attention to the established, immutable facts of that science (art, *if* you prefer) we profess to be masters of, and less to the contradictory, chimerical, evanescent theories of the dominant school, the difference in the death rates would be greater, and our standing as a school and as practitioners more creditable and more assured. One correspondent writes: "I would like to end by saying that any physician who has a patient suffering from typhoid fever in bed over twenty-one days owes that patient an apology. By pursuing the above methods (quite free from allopathic procedure—Peck) for the last seventeen years I have had to apologize to but two patients, each of whom spent twenty-eight days in bed. I regard a death from enteric fever as a blot upon the medical profession." Compare this with the statement of an eminent allopathic authority: "Typhoid fever is a self-limited disease, *tending to recovery!*"

NOTE.—To secure percentages for convenient comparison in the four paragraphs relating to remedies strike out the right hand figure; in all other cases multiply by four and strike off as before, remembering always to increase the unit figure left standing by one, should the number erased be 5 or above.

NOTE 2.—Since forwarding this paper to the HAHNEMANNIAN MONTHLY, a reply has come to hand from Edward Blake, M.D., of Hyde Park, England, which I venture to summarize. His four principal remedies are arsenicum album, mercurius corrosivus,

baptisia and muriaticum acidum. For cerebral symptoms he finds most frequently indicated belladonna, helleborus niger, phenol and hyoseyamus: for diarrhœic arsenicum album, veratrum album and gummi guttæ (for gurgling in iliac fossæ with pain): for intestinal hæmorrhage only cuprum sulphuricum. He might inject ergotin to check intestinal hæmorrhage, but has never done so. His dietary is water, whey, milk, egg, beaten with water, fruit-juice. He diets his patients for six to twelve months afterward: no cellulose, no cellular tissue, no *débris*, no refuse of any kind. Food every two hours. "Having been clinical clerk to the great Sir William Jenner, I let all my patients die drunk. Have been through four severe epidemics. I have repeatedly taken off a pint of spirit given by my predecessor *per diem* to a desperate case. I have never lost a case." He orders hot water sponging twice a day. He does not employ tub-baths, very cold or iced water, enemata, flushing the colon or intestinal antiseptics, "save by arsenicum and mercurius in homœopathic doses."

POTASSIUM BICHROMATE IN GASTRIC DISORDERS.—A correspondent of the *Monthly Homœopathic Review* (October 2, 1899) calls attention to a paper communicated to the Eleventh International Medical Congress, held in Rome, by Prof. Fraser, of Edinburgh University. That eminent authority on materia medica and therapeutics states that having in 1884 treated with gratifying success a case of persistent gastric disorder by the administration of small doses of bichromate of potassium, he has since that time administered it in a large number of cases. The results have been so favorable that he feels himself justified in now stating his opinion of the therapeutic value of the substance and in briefly recording a number of cases.

His cases are recorded in two groups—the first group comprehending cases of various forms of dyspepsia unassociated with evidence of gastric ulcer; and the second group, cases in which distinctive symptoms of ulcer had been present at some previous time. In conclusion he states that "while the doses administered in the above cases have varied from $\frac{1}{12}$ gr. to $\frac{1}{6}$ gr. (from 0.005 to 0.01 gramme) thrice daily, it will be observed that in the greatest number of the cases the smallest of these doses was administered and was found sufficient. The dose should be given during fasting, and in as empty a condition of the stomach as possible. The administration was effected in the form of pill or solution; and no difficulty was experienced by the patient in the taking of a simple solution in water, although occasionally, and especially with the larger doses, flavoring extracts were added, such as syrup of tolu or of orange. An examination of these records show that bichromate of potassium is capable of relieving, and often in a short time of removing, the entire group of symptoms—if we except constipation and anæmia—encountered in dyspepsia, and especially pain, nausea, vomiting and gastric tenderness.

EDITORIAL.

WM. H. BIGLER, A.M., M.D.

WM. W. VAN BAUN, M.D.

DECENCY IN MEDICAL JOURNALISM.

THE Power of the Press has long been a favorite theme of after-dinner toasts, not to mention the speeches of attorneys and the charges of judges in libel suits. It is a strange but indubitable fact that a statement appearing in print usually gains more immediate credence than when made orally, except perhaps with those pessimists who have learned from personal experience or observation that even print may lie. Whether it is that, with the idea of printing, we unconsciously associate the idea of more care and forethought than is usually bestowed upon the spoken word, or whether it is that the impersonality of the type itself seems to lend a halo of impersonality and elevation above the weaknesses and foibles of the common personal man, we know not, but that we are inclined to be unduly influenced by the press of all kinds,—theological, legal, and medical,—can hardly be doubted.

With power come responsibility and certain duties, which must be recognized if the press is to be the power for good which it is claimed to be. We do not intend to enumerate the duties which one may legitimately consider as incumbent on journalism, but were we disposed to inflict a homily upon our readers, we could reel off firstlies and secondlies, in addition to the one fundamental demand for truth. In medical journals this demand for truth, absolute truth, is far in excess of the supply. The limitations surrounding the advancement of medical science are such that much of what ought to and does appear in medical literature is tentative and hypothetical, or at least will be so regarded by all those who have seen the heresy of to-day so often become the dogma of to-morrow, and *vice versa*. But in spite of this there should always be evident in medical literature an earnest desire for and search after the

truth, wherever it is to be found, unhampered by tradition and unfettered by prejudice or predilection.

The manner of presenting the truth is not a matter of indifference, for, as we all know, the truth can be made to assume a very repellant or a very attractive aspect, according to the garb in which it is introduced. It may be decked out in all the beauties of refined rhetoric, or it may be clad in an armor of invective; it may be gently suggested, or aggressively hurled at the heads of its supposed opponents; but one thing which all right-minded persons can and should demand is, that its garb should at least be clean. Medicine has to do with so many subjects which lie outside the pale of the ordinary decent lay mind, so many truths which concern the most private thoughts and acts of humanity, that the medical journal is called upon to exercise constant vigilance that the treatment of such topics should be characterized by cleanness—cleanness of thought, as well as cleanness of expression. What might perhaps be condoned or judged leniently if occurring in the relaxation of a post-prandial coterie of physicians ought never to gain access to or be embalmed in the pages of a medical journal.

We were started on this train of thought by the perusal of the September number of a journal devoted to a special, much vaunted and much exploited, method of treatment—one which from its very nature should be spoken of and discussed with peculiar carefulness and decency if it would avoid meeting something worse than mere tolerant skepticism. We do not wish to appear hypercritical or prudish, nor do we wish to arouse feelings of resentment in the broad bosoms of any of our co-laborers, but we are compelled to say that most of the subjects treated in the journal referred to are handled and discussed in a way which reflects no credit on the adherents of the specialty which it seeks to further. They smack rather of the closing confidentially reminiscent period of a stag-party than of a scientific discussion of important truths.

No doubt, to the pure all things are pure; but there is such a thing as purity being made to wear the garb of impurity. It is too much the fashion to treat of matters relating to the sexual function with a libidinous leer, poisonous enough to transform a scientific truth into a smutty bar-room joke, which,

if it can be made to tell apparently against the purity, or chastity, or continence of the female sex, becomes thereby all the more enjoyable. There are many who seem to have forgotten, in their endeavors to hold it up to the worst kind of ridicule, that their own mothers and sisters belong to the female sex. We regard this tendency as one form of sexual perversion, and those who further it as dangerous sexual perverts. Let us put ourselves in the place of the public. Would we willingly and knowingly entrust the care of our wives and daughters to these sexual perverts, in whose minds there seems to be a foul pool, out of which all truths rise dripping and reeking with the excretions of a lascivious and perverted imagination? These are hard words, and yet we feel they are not too hard for the cases to which we apply them. We do not intend them to be applied to those whose papers and discussions have given rise to this diatribe, but to those who —. But we prefer our readers to make their own application; it is easily done.

Fortunately it is not often that medical journalism, especially as conducted here in the East, is disgraced by evidences of the existence of this kind of insanity in members of the medical fraternity.

If we wish to hold the confidence of the public, if we would retain our own self-respect, we must see to it that, in the discussion of subjects of this nature, we do not allow scientific truth to be besmirched by pruriency and vulgarity. Finally, all who have the best interests of their profession at heart must openly and without fear insist that medical journalism be kept free from these vices.

ANACARDIUM AS A REMEDY IN MENTAL DISEASES.—As Halbert, writing editorially in *The Clinique* (October 15, 1899) says, the tendency to overcome mental excitement by hypnotics is natural, and the use of sedatives will probably always be resorted to in preference to waiting for the action of a remedy which represents symptomatic requirements. And yet there is less reason for this in mental conditions than any other diseases. Accordingly, he recommends the study of anacardium, of whose two varieties the orientale is the more efficacious in mental disease. In this age, in which mental energy is used to the extreme, it will be very useful for that fatigue of mind so often called "brain fag."

The danger of using anacardium too strong or too long, should not be overlooked. The poisonous action upon the skin is liable to create irritable eruptions resembling variola. Then, too, it is often toxic even in attenuation, and for that reason should be watched constantly.

GLEANINGS.

TREATMENT OF CORPULENCE.—V. Hoesslin commences an article on this subject with the statement that having, during six years, treated corpulence on Oertel's principle, by limiting the amounts of fluid taken, he has abandoned this method because (1) the patients suffered greatly from thirst and hunger, and were disturbed in their general health; (2) many of the patients so treated became severely neurasthenic and sleepless; (3) the loss of fat was, in most cases, considerable for some weeks, but after that it seldom bore any relationship to the trouble and suffering caused by the dietary.

During some years he has adopted the following principles in treating these cases: (1) A purely proteid and fatty dietary; (2) stimulation of the metabolism by hydrotherapy; (3) administration of thyroid gland; (4) increase of tissue oxidation by means of exercise. This diet suffices; no feelings of hunger or thirst are experienced while living on it, and it can be continued for months without injury to the general health.

For breakfast, tea or coffee, with cream, but without sugar; brown bread and plenty of butter are allowed. Fish, fowl, flesh, cheese, butter, cream and other fats, with those fruits and vegetables which are as free as possible from sugar and starch, make up the dietary. Water, mineral waters and thin wines are the drinks allowed. No restriction is placed on the amount eaten or drunk.

The hydropathic treatment consists in cold baths of different kinds, which promote oxidation of the body fat, and in baths which induce free respiration.

Thyroid preparations must be used with great caution, as they promote wasting of muscle as well as of fat. A small dose is given, and its effect on pulse watched, as patients react strongly in some cases and scarcely at all in others. Its use greatly hastens the loss of weight, but it should not be continued if it produces any other effects.

Exercise consists in tennis, riding, bicycling, sawing and cutting wood, hill-climbing, rowing, etc.

A combination of all four methods gives much more satisfactory results than any one of them alone. A day's programme during the cure is somewhat as follows: 6.30 A.M. Cold sponge; walking or other exercise from half an hour to three-quarters of an hour. 7.30 A.M. Breakfast, tea or coffee, with cream; one slice brown bread, thickly spread with butter. 8.15 A.M. Vapor bath every second day, alternated with cold bath. 9.30 A.M. One egg or a slice of fat bacon. 10 A.M. to 12.30. Exercise. 12.30 P.M. Lunch, bouillon and egg, fat meat with salad, an apple, some brown bread, mineral water, and one thyroid tablet. 1.30 P.M. Rest, and then a cup of tea or coffee. 3.15 to 6.15 P.M. Exercise. 6.30 P.M. Cold douche. 7 P.M. Dinner of proteid food and green vegetables chiefly; one thyroid tablet. Billiards or skittles may fill up the evening.—*Edinburgh Medical Journal*, November, 1899.

THE FEVER OF TUBERCULOSIS.—Bernheim, in a communication to the French Academy of Sciences, states that three varieties of hyperthermia are produced in the different manifestations of tuberculosis, viz., (1) Pure bacillar fever; (2) Septic fever; (3) Hectic fever. The pure bacillar form may be created experimentally, as seen, too, in miliary tuberculosis, meningitis, certain varieties of pleurisy, pericarditis and tubercular peritonitis. The septic fever due to the toxins of other bacteria than the bacillus of Koch is observed in sub-acute phthisis, in tubercular pneumonia during the second stage of common phthisis, and in a large number of surgical forms of tuberculosis with various lesions. Hectic fever is due to the association of the bacteria of suppuration with Koch's bacilli, the toxins of which are reabsorbed and produce general poisoning of the whole organism. This poison rapidly produces cachexia and ends in death.—*Med. Times*, Nov., 1899.

F. Mortimer Lawrence, M.D.

THE URINE AS A DIAGNOSTIC FACTOR.—Kernode quotes the rules first formulated by Formad, which are as follows:

1. Sediment in the urine has no significance unless deposited within twenty-four hours.
2. Albumin in the urine does not indicate kidney disease unless accompanied by tube-casts. The most fatal form of Bright's disease—contracted kidney—has little or no albumin.
3. Every white crystal in urine, regardless of shape, is a phosphate, except the oxalate of lime crystal, which has its own peculiar form; urine alkaline.
4. Every yellow crystal is uric acid if the urine is acid, or a urate if the urine is alkaline.
5. Mucous casts, pus and epithelium signify disease of the bladder, cystitis, or of other parts of the urinary tract as determined by variety of epithelium.
6. The urine from females can often be differentiated from the urine of males by finding in it the tessellated epithelium of the vagina.
7. Hyaline casts (narrow), blood and epithelial casts signify acute catarrhal nephritis. There is much albumin in this condition.
8. Broad hyaline casts and epithelial dark green granules and oil casts signify chronic catarrhal nephritis. At first, much albumin; later, less.
9. Hyaline and pale granular casts and little or no albumin signify interstitial nephritis.
10. Broad casts are worse than narrow casts, for the former signify a chronic disease.
11. The urine should be fresh for microscopic examination, as the micrococci will change hyaline casts into granular casts, or devour them entirely in a short time.
12. Uric acid may, in Trommer's test for sugar, form a peroxide of copper, this often misleading the examiner into the belief that he has discovered sugar. Thus, when urine shows only sugar, other methods of examination must be used—preferably the lead test.
13. The microscope gives us better ideas of the exact condition of affairs in examination of the urine than the various chemical tests.—*Tri-State Med. Journal*, Nov., 1898.

F. Mortimer Lawrence, M.D.

THE PRESERVATION OF CASTS FOUND IN URINE.—Boston has found the following mixture very useful: Liquid acidii arseniosi (U. S. P.) 1 fluidounce;

salicylic acid, $\frac{1}{2}$ grain ; glycerin, 2 fluidrams. This is slightly warmed until solution is effected, when "whole tears" of acacia are added to saturation. After subsidence, the supernatant liquid is decanted. A drop of 40 per cent. formalin may be added to this mixture. The ordinary deposit obtained by standing is collected with a pipet and placed on the centre of a slide. It is then viewed with a low power, and, if casts are present, evaporated nearly to dryness, after which a drop of the above solution is added to the centre of the drop of urine. In order to completely mix the two, and to distribute the casts through the field, the mixture is stirred gently with a fine needle. A cover-glass is applied, and the slide put in a cool place for a few hours until hardening is complete, when a permanent ring of zinc white completes the preservation of the specimen.—*N. Y. Med. Jour.*, Nov. 4, 1899.

F. Mortimer Lawrence, M.D.

THE DIAGNOSIS OF FLOATING KIDNEY.—According to Laphorn Smith, the following symptoms of floating kidney are particularly to be noted when the disease simulates some affection of the genital organs in women :

1. Disorders of digestion, accompanied by pain, not only in the right side, but more especially in the left. These pains may be characterized as cardialgia or gastrodynia.

2. General nervousness, the transforming of a naturally sweet temper to irritability, with loss of sleep.

3. Palpitation of the heart, coupled with pain over the cardiac end of the stomach.

4. The usual symptoms directly due to the displacement of the kidney, together with the marked emaciation so strong an etiologic factor of floating kidney.

Smith advocates the invariable use of the semi-erect posture of the patient in examining for floating kidney. The patient should stand, leaning slightly forward, with her hands on the back of a chair, so as to relax the abdominal muscles, while the examiner sits to the right and a little behind.—*Jour. Am. Med. Assoc.*, Nov. 4, 1899.

F. Mortimer Lawrence, M.D.

THE DIFFERENTIAL DIAGNOSIS OF TYPHOID FROM MALARIAL FEVER.—According to Osler, two rules should guide practitioners above Mason and Dixon's Line : (1) an intermittent fever which resists quinine is not of malarial origin ; (2) in those localities (in which the estivo-autumnal organism and the graver forms of disease caused by it are very rare) a continued fever is not due to malarial infection.

So exceptional are cases of continuous fever with tertian infection that they need not be considered, but the estivo-autumnal fever may simulate typhoid very closely. There are two points in the differentiation of these conditions which are important, viz. : the fever in malaria is marked from the outset by remissions of a grade rarely seen in typhoid until the late stages, while once the fastigium is reached in the latter the fever presents a remarkable steadiness. The early anemia with sallow complexion often suggests the diagnosis, even when other symptoms are like those of typhoid. It is in these cases that the enormous diagnostic value of Laveran's discovery is appreciated. Unfortunately the parasite of the estivo-autumnal fevers is less easily recognized in the acute stages than the larger tertian form ; and, moreover, it may be

very scanty in the circulating blood. The recognition of an estivo-autumnal infection of a week or ten days' duration is easy from the presence of ovoids and crescents.—*N. Y. Med. Jour.*, Nov. 4, 1899.

F. Mortimer Lawrence, M.D.

DETECTION OF SMALL QUANTITIES OF ALBUMIN IN THE URINE.—Clifford Mitchell, M.D., Chicago, after a detailed review of the various tests for the detection of albumin in the urine, is unable to suggest any simple method for the detection of very small quantities of albumin which can be relied on in all cases, but thinks that when cold nitric acid fails to give a ring the urine should be tested as follows :

1. Filter the urine once or twice through three thicknesses of filter paper.
2. Add to the filtered urine 10 per cent. its volume of an 80 per cent. solution of calcium chloride crystals.

3. Filter again through three thicknesses of paper, ceasing to filter before the filtrate becomes in the least degree cloudy.

4. Float the last filtrate in equal parts on an inch of Spiegler's solution.

If no ring appears in less than five minutes, albumin in quantity 1 part in 100,000 is absent. If albumin in this quantity or more is present, a ring will appear in less than five minutes.

Great care must be used in floating the filtered urine on the test solution, or the two will mix in such a way that no ring at all will be seen. The writer has noticed that a ring generally appears, when albumin is absent, after ten minutes or more, but when albumin 1 part in 100,000 is present the ring appears promptly ; that is, in less than five minutes.—*N. Y. Medical Times*, Nov., 1899.

W. D. Carter, M.D.

TYPHOID FEVER ACCOMPANIED BY SWEATING.—Sudoral typhoid was described by Jaccoud in 1883, and later studied by French and Italian writers. It is frequent in the latter country.

It begins suddenly without prodromes, with headache over the eyes and in the back of the neck. Then during the next twenty-four to forty-eight hours a long-lasting chill follows which simulates an intermittent. The sweats are profuse, and the attacks last from six to twelve hours. The headache increases to the tenth or twelfth day. After the initial febrile attack a feverless period succeeds until the next day at the same hour, when another rise of temperature occurs. The patient resembles in the face a typhus patient, and there always is a profuseness of sweats.

During the second period, or that of remittance, the fever is continuous, with very pronounced paroxysmal aggravations, which may be three, four and even five times during a single day, with a chill, sense of heat, of local cold, and always in the same place in the same patient. The hours of the attack have no regularity, and the course of the disease is no more regular. There may be several periods of maximal elevation during a day, and the highest point is not always in the evening. This second period lasts about three weeks, and the reduction of the paroxysms announces the third period, which is intermittent with morning apyrexia. This stage, though the temperature may be normal at night instead, lasts from five to ten days. The sudoral character of the paroxysm persists until the end. There are no cerebral symptoms as in ordinary typhoid ; constipation is the rule ; the tongue is moist and clean,

and the enlargement of the spleen does not persist. There is an absence of broncho-pulmonary symptoms and albuminuria. The rash is not always present. Intestinal hæmorrhage is frequent. The prognosis is nearly always favorable. Between this type and the ordinary form there is a whole series of mixed cases. They may present but a certain number of symptoms characteristic of sudoral typhoid, while the others are those of the ordinary variety. Deaths and relapses, however, have occurred. The closer the case approaches the regular typhoid, the greater the danger.

Exanthematic typhus resembles it, though that is rare in America; grippe in certain epidemics may give rise to a similar picture. Malta fever is a similar fever with pains in the joints. In sudoral typhoid there is nothing in common with intermittent, nor is there any double infection with typhoid and malaria. Quinine is both inefficacious and dangerous. In one case the sero-reaction was positive, and puncture of the spleen revealed the typhoid bacillus.—*Journal des Praticiens*, No. 40, 1899. A condition that might easily be confused with this is miliary tuberculosis, or pulmonary tuberculosis following a latently developing focus in the lungs which was suddenly fanned into flame by whooping-cough or measles. Prof. G. Cornet—*Die Tuberculose*, p. 342, 1899—mentions an intermittent form of tuberculous fever, and speaks of a case where it was accompanied by actual paroxysms. The manner in which a sudoral typhoid begins would make one think of a miliary tuberculosis. Examination of the blood would exclude an intermittent, though in earlier years practitioners were accustomed to depend on the quinine test. The cryptogenic pyæmic states and septico-pyæmic condition as ulcerous endocarditis must also be excluded.

Frank H. Pritchard, M.D.

INDURATED PHLEGMONS OF THE NECK.—Dr. Kusnetzoff relates the case of that peculiar and somewhat rare affection which has been described by Reclus as "phlegmon ligneux." A man of 69 years, for several months after an attack of tonsillitis, had been affected with a hard and well limited induration extending from the chin to the upper border of the thyroid cartilage on both sides. It was hard, painless, immobile, not sensitive to pressure, and the seat of no pain, though it interfered with deglutition and movements of the head. The cervical lymph-glands were not enlarged. Pulse and temperature normal. A malignant neoplasm was suspected and an operation advised. As K. detected a slight infiltration of the skin it was regarded as inflammatory. Poultices were employed, and in four days a spot softened in the centre of the tumor, while the temperature went up to 38.4°. Two incisions liberated thick and fœtid pus with a piece of necrotic tissue. The temperature went up to 39°, and a chill followed. Another incision revealed a pus collection between the larynx, the deep muscles of the neck and the neuro-vascular fascia. Ten days later an enlarged gland was discovered below the right clavicle, which was removed. The lardaceous infiltration which surrounded each of these abscesses was slowly absorbed. The patient wholly recovered. Bacteriologically there were streptococci of slight virulence and some bacilli of the proteus genus. In the pus in the gland there were only bacilli.—*La Semaine Médicale*, No. 42, 1899.

Frank H. Pritchard, M.D.

A FEW POINTS ON MALIGNANT ULCEROUS ENDOCARDITIS.—Prof. William Ebstein, of Goettingen, from a study of ten cases of this disease, distinguishes

an acute, a subacute, and a chronic course. The earlier that cerebral symptoms set in, the more rapidly the disease runs its course to a fatal ending. The local signs in the cardiac valves themselves are of no prognostic value, but only the grouping of the general symptoms and signs. The fever is of primary importance by its atypical course and great elevations and depressions, "jumps." An inverse type sometimes is noted. If an endocarditic process cannot be diagnosed, one may be obliged to be satisfied with a diagnosis of cryptogenic sepsis. Neither one or more initial chills nor erratic course of the temperature permit one to diagnose metastatic abscesses, or even embolic processes. The pyæmic form may be assumed only when metastatic suppurative foci are recognizable by other means. The typhoid form is only to be diagnosticated when all other diseases capable of causing a typhoid state may be excluded. At times in such cases examination of the blood may be of service.—*Wiener Medizinische Presse*, No. 38, 1899. In the typical variety of this disease, which is not easy to diagnose, one is never certain when an embolus will not lodge. In a case of this disease which recently died, I first noted an embolism of the spleen, then a hemiplegia, this being followed by an embolism of the mesenteric arteries, with a number which lodged in the lower limbs. A second attack of hemiplegia came on some months after, associated with aphasia and akataphasia. When the patient had recovered she had occasional attacks of smaller emboli in the toes, knees, fingers, hands, etc. Finally a very severe one came on, with an attack of vomiting, she became unconscious, and after lying unconscious for almost a week, unable to speak, swallow or move, death released her. The erratic fever was a marked sign. The menses ceased for several months. There was also a complicating tuberculosis of the lungs of a slight grade.

Frank H. Pritchard, M.D.

PURPURA IN TYPHOID FEVER.—Dr. E. Robert has observed two cases of this complication, purpura, in typhoid fever. Bacteriologically, a very virulent typhoid bacillus in company with a non-virulent coli bacillus was detected in one case, while the very virulent bacillus was found alone in the other. The appearance of purpuric spots during a typhoid aggravates the prognosis, it indicating a serious poisoning by toxins which should be energetically combated by favoring by all possible means the elimination of toxins.—*La Settimana Medica*, No. 37, 1899. This must be a very rare complication, for neither Curschmann—*Der Unterleibs-Typhus*—nor Osler mention it. Curschmann speaks of Murchison and Liebermeister describing a hæmorrhagic variety of typhoid fever.

Frank H. Pritchard, M.D.

THE EARLY DIAGNOSIS OF MEASLES.—Dr. Rolly, Professor O. Vierordt's assistant in the Poliklinik of the University of Heidelberg, confirms the value of Koplik's sign in the early diagnosis of measles. They are small bluish-white spots of the size of the head of a pin on the mucous membrane of the cheeks near the molar teeth, surrounded by a reddish areola. These latter become more and more pronounced, though the spots do not confluence, nor do they leave any lesions after disappearing. They vary from six to twenty in number. Thus one is enabled to diagnose the disease four to six days before the skin eruption appears.—*Muenchener Medizinische Wochenschrift*, No. 38, 1899. Filatow—*Acute Infektionskrankheiten*, 1895, p. 349—called attention still earlier to a bran-like desquamation of the epithelium of the mucous

membrane of the lips and cheeks, in the diagnosis of measles. In one case he was able to detect the disease six days before it broke out.

Frank H. Pritchard, M.D.

A CASE OF ACUTE DILATATION OF THE STOMACH.—Dr. Kirch was called to a weakly kypho-scoliotic man of nineteen years who, after a very heavy meal, had been taken with violent and gradually increasing colicky pains. His pulse was 146 and small, the abdomen distended, and the lower left portion of the abdomen was filled with a fluctuating mass, which was absolutely dull on percussion, and beginning at the symphysis pubis extended in a curved line around the umbilicus up to the left arch of the ribs, and filled the whole left iliac fossa. This was very sensitive to pressure. A local peritonitis was diagnosed of doubtful nature, and an operation was proposed. A colleague, called in consultation, hinted that it might be an acutely dilated stomach. Indeed, on shaking the patient, a loud splashing sound was to be heard, and the stomach was syphoned out. Over three litres of fluid were drawn off. Although the patient immediately felt better, his condition soon became worse, and death finally followed.

The necropsy revealed a colossally dilated stomach which actually was nothing but a great sack. The walls were very thin. Death had occurred from shock.—*Deutsche Medicinische Wochenschrift*, No. 33, 1899.

WRY-NECK IN OTITIS MEDIA.—Dr. Biehl has observed several cases of wry-neck accompanying otitis media. In one it was due to a thrombosis of the jugular vein which had originated in a thrombus of the sinus sigmoideus. In a second case pus had burrowed from the mastoid process into the sheath of the sterno-mastoid. In a third case the pus had escaped through the petro-squamous fissure into the substance of the sterno-mastoid.—*Berliner Klinische Wochenschrift*, No. 39, 1899.

Frank H. Pritchard, M.D.

TYPHOID FEVER BACILLI IN THE URINE.—Dr. Gwyn asserts that in 20 to 30 per cent. of typhoid cases the bacillus is found in the urine, which, by the way, is an excellent culture-medium for this micro-organism. Usually they are present in a pure culture, and so numerous that they frequently render the urine turbid, and are to be demonstrated under the cover-glass. They appear in the urine in the second and third weeks, and may be excreted for months. Prognostically of no importance, they point to the necessity of disinfecting the urine in such cases.—*Berliner Klinische Wochenschrift*, No. 39, 1899.

OVARIAN TUMORS OF UNUSUAL SIZE.—Dr. Woerner has operated on several ovarian tumors of unusual size, and come to the conclusion that the operation even in very old women is devoid of serious risk. He does not advise puncturing, but after making an incision twenty cms. long, and loosening the adhesions, slowly to evacuate the tumor by incising into it. By application of a firm compressing bandage, pulmonary disturbances from decreased abdominal pressure are to be prevented.—*Archiv fuer Klinische Chirurgie*, Bd. 59, Hft. 2.

Frank H. Pritchard, M.D.

PRELIMINARY REPORT OF A CASE OF ACUTE GENERAL SEPTIC PERITONITIS TREATED BY CONTINUOUS IRRIGATION WITH WARM NORMAL SALT-SOLUTION.—Laplace (Philadelphia), in a case of general septic peritonitis due to appendicitis, after the usual operative procedures, made use of an unique method of applying continuous irrigation to the abdominal cavity as a possi-

ble means of arresting the infection in the peritonæum. The glass nozzle of the irrigator still attached to the tube was introduced down to the Douglas cul-de-sac, and fixed by a stitch to the abdominal wall. An ordinary glass drainage-tube with rubber tubing was placed about three inches above. The intervening wound was packed, and the remainder of the incision sutured. The patient was placed in bed on a Kelly pad, and a continuous flow of normal salt-solution at a temperature of 100° F., from an irrigator suspended over the bed, was allowed to enter the abdomen by the lower tube, escaping through the upper tube, and through the wound. This was kept up constantly, day and night, for seventy-two hours, at a rate of ten pints every fifteen minutes, a total of three hundred and sixty gallons for the three days. The pulse dropped from one hundred and eighty during the operation to ninety-eight on the day following, and two days later was sixty. The temperature came down gradually from 100° F. to 98.5. At the last report, nine days from the time of operation, the patient was in excellent condition, and convalescing rapidly. There was no discomfort connected with the treatment, although the patient could feel the warm water circulating through the abdomen.

The copious irrigation, reaching the most dependent portions of the peritoneal cavity, dissolved and carried off the toxins as they formed, allowing phagocytosis a free scope to permanently destroy the infectious bacteria. This method is in accord with already well-established surgical principles, only novel in its application to the peritonæum, and, judging by the happy termination of this case, worthy of further trial.—*Philadelphia Medical Journal*, October, 1899.

Gustave A. Van Lennep, M.D.

FORCIBLE CORRECTION OF THE ANGULAR DEFORMITY RESULTING FROM SPINAL CARIES.—Bradford and Vose (Boston) think that the clinical application of the method must necessarily be limited to certain conditions. Where recovery has taken place, with deformity, it would seem unsurgical to attempt to straighten the osseous ankylosis. The existence of an abscess would be a contraindication to forcible straightening. Correction by the rapid method, *i.e.*, anæsthesia and sufficient force to overcome the deformity entirely at one sitting, amounting to a fracture of the spine, is a dangerous procedure, and in the opinion of the authors should be replaced by the gradual method, perfected by Goldthwait, and now in use at the Children's Hospital, Boston. In this the diseased projection is used as the resistant point, and the weight of the body on each side of this acts as a straightening force. A plaster-of-Paris jacket is then applied, and the procedure repeated as often as may be necessary till healing has taken place. No anæsthetic is used and the patient suffers but little discomfort. The writers suggest a simple way by which this plan may be carried out, doing away with the use of the frame heretofore necessary. The patient is placed on his back on a table. A sling made of stout cloth is passed under the most prominent point of the kyphosis, the latter being well padded, and fastened to a cross-bar above the patient. By raising the cross-bar, the patient can be lifted clear from the table, so that the weight of the whole trunk acts as a correcting force. The jacket can then be applied, working it around the sling, and the ends of the latter cut off at their points of emergence. The cases most suitable are those in which the disease is situated in the lower dorsal or upper lumbar regions, and before osseous ankylosis has taken place.—*Annals of Surgery*, Nov., 1899.

Gustave A. Van Lennep, M.D.

THE OPERATIVE TREATMENT OF FRACTURE OF THE PATELLA.—Bishop (New York) strongly recommends the open operation for fractures of the patella occurring in adults. The longitudinal incision is used, cutting down to the capsule with one stroke of the knife. After cleaning the joint and fractured surfaces of blood clots, and securing all bleeding points, the overhanging shreds of capsule and periosteum are trimmed away. Using chromicized catgut, the torn periosteum and capsule are stitched together with interrupted sutures, paying particular attention to the correct approximation of the posterior part of the ruptured capsule. To do this the fragments are tilted up. The wound is closed, no drainage being used, and the leg placed in a plaster-of-Paris cast in the extended position. At the end of four weeks the patient is allowed to walk, but the cast is worn two weeks longer, removing it each day for massage.

Passive motion is begun at the end of five weeks. At the end of six weeks the patient may walk without the support of the cast. Forceful flexion of the knee is not practised. The results of six cases operated within the last eighteen months have been uniformly good, perfect function having been obtained in the older cases.

The advantages to be derived from the open operation are as follows:

1. Short period of confinement to bed.
2. Ability to walk and do light work in five or six weeks.
3. Freedom from the pain of frequent dressing, especially where adhesive plaster straps are used.
4. Opportunity to have muscles of thigh massaged, and thereby prevent atrophy.
5. Less liability of refracture, since the union is bony.
6. Less danger of fracture of opposite patella occurring from over-development of muscles of thigh on account of increased work of the uninjured side during the many months of disability from the fracture.—*North American Journal of Homœopathy*, Nov., 1899.

Gustave A. Van Lennep, M.D.

RESECTION OF THE LIVER FOR A NEOPLASM.—Keen (Philadelphia) reports a case of removal of the entire left half of the liver for carcinoma. The growth was entirely confined to the portion of the liver removed, and there was no lymphatic involvement. The removal was done entirely with the Paquelin cautery, and required about thirty minutes. Hæmorrhage was not severe except where some of the larger veins were burnt. These required the application of a ligature. Parenchymatous bleeding was readily arrested by temporarily packing the raw surface with iodoform gauze. When the tumor was removed, part of the resulting raw surface was obliterated by folding the edge of the liver upon itself, like the flaps of an amputation, and secured in place by catgut sutures. The remainder of the hepatic wound was packed with iodoform gauze, leaving the end protruding through the abdominal wound. As a precautionary measure against shock, infusion was performed while the operation was going on, a quart of saline solution being introduced into the circulation.

Hiccough and vomiting were the only annoying post-operative symptoms. These continued for forty-eight hours, and were finally controlled by washing out the stomach. On the removal of the pack on the second day there was quite a free discharge of bile, which gradually diminished and ceased entirely

by the twelfth day. The sinus closed slowly, the patient making an uneventful recovery.—*Annals of Surgery*, September, 1899.

Gustave A. Van Lennep, M.D.

THE TREATMENT OF EPIDIDYMITIS.—Kenner (Louisville) has treated fifteen cases by the following method, in all of which he was able to control the acute inflammation rapidly, and shorten the stage of resolution: To control pain, tobacco leaves wet in water as hot as can be borne, are applied directly to the scrotum and changed as quickly as they become cold. At times this treatment causes *nausea* or irritates the skin and has to be discontinued. When the tenderness and pain diminish, iodine vasogen is rubbed into the scrotum every three or four hours, till resolution is accomplished. This agent is not an irritant, and should be used in place of tincture of iodine. The average time for recovery has been five days. The author has tried the administration of pulsatilla tincture, but with no marked success.—*The New York Medical Journal*, November, 1899.

Gustave A. Van Lennep, M.D.

MANIA AND MELANCHOLIA DUE TO PELVIC TROUBLE.—T. K. Holmes, M.D., Chatham, Canada, finds that puerperal mania is invariably accompanied by some lesion of the generative apparatus, and that when this was cured, in many instances the mania got well. After investigation he, in 1885, was able to present reports of puerperal mania before the Canadian Medical Association, in which complete cures had followed repair of laceration of the cervix.

Besides twenty-eight cases of puerperal mania, two cases of insanity in unmarried women, due to granular erosion of the cervix, three cases of melancholia of a grave character, due to fibroma of the cervix, and two cases of melancholia due to dislocation of the kidney have recovered upon the cure of these exciting causes.—*American Journal of Surgery and Gynecology*, Oct., 1899.

W. D. Carter, M.D.

OBSERVATIONS ON THE RELATION OF THE UTERUS TO THE THYROID GLAND.—Charles R. Dickson, M.D., Toronto, Canada, reports his observations upon the above. His experience relates to two hundred cases and are as follows:

“A direct sympathy, if nothing more, between the uterus and thyroid is manifested in many ways—so frequently, in fact, as to preclude the assumption of mere coincidence. Thus, before the establishment of the function of menstruation the thyroid gland is quite often found to be in a hyperæmic or engorged condition. When menstruation is established this condition of engorgement usually disappears, although it may occasionally persist in a lessened degree. In the cases in which the thyroid does not resume its normal dimensions it usually becomes more engorged before each menstrual period, receding in size upon completion of the period; or, again, there may be an accession in size at each period, which does not entirely disappear.

“Enlargement of the thyroid, however, is not always a premonitor of approaching puberty—it is met with in children under eight years of age. Goitre occurring after puberty is frequently associated with amenorrhœa. Treatment directed to the amelioration of this condition established menstruation and reduced the thyroid. In only one case has a diminution in size of a goitre during the menstrual period been noted—a parenchymatous goitre in a multipara.

"When a patient with an enlarged thyroid becomes pregnant the gland increases markedly in size with each pregnancy, to become smaller upon or shortly after delivery, although it rarely recedes to its dimensions before pregnancy.

"In many cases pregnancy is directly responsible for goitre, which makes its first appearance early after impregnation.

"In several cases it has been noticed that while the thyroid gland was undergoing electrical treatment the susceptibility to impregnation has been markedly increased, and this with patients that had not been pregnant for several years.

"The occurrence of the menopause is not always the signal for the recession or disappearance of a goitre; on the contrary it may increase at this period. In a few cases the goitre has not given rise to any inconvenience until the menopause. A goitre, especially manifest after the climacteric, should be regarded with suspicion as apt to be malignant in character.

"At three periods of life has the thyroid been most refractory to treatment: before puberty, during pregnancy and after the menopause."—*Charlotte Medical Journal*, October, 1899.

W. D. Carter, M.D.

HEREDITY OF PTOSIS PALPEBRARUM.—M. Münden, of Hamburg, relates that in 1820 a woman was crossing the river in a boat when it upset, and in her struggle the eyelids were convulsively closed; rescued and revived, the lids were permanently affected with ptosis. Pregnant at the time, when she gave birth to the child it was also affected with permanent ptosis palpebrarum. This child grew up and bore three children, two normal and one with the same congenital ptosis. The latter is still living, and one of his children is also affected in the same way.—*Deutsche Med. Woch.*

William Spencer, M.D.

THE USE OF SUPRARENAL EXTRACT IN CONJUNCTION WITH COCAINE TO OBTAIN BLOODLESS AND PAINLESS OPERATION.—In addition to the hemostatic properties of suprarenal extract, which may be best obtained by the application of a pad soaked in strong solutions, 50 per cent. or less (in terms of weight of dried gland), the extract is extremely useful in operations on the nose, throat and ear. As I have shown elsewhere, for small amounts the limit of decided physiological effect is for suprarenal extract (in terms of dried gland) $\frac{1}{4}$ per cent., for cocaine, $\frac{1}{8}$ per cent. dilution. I find the ordinary solution of 10 per cent. suprarenal extract and cocaine useful for the nose and pharynx, while combined 20 per cent. solutions are best for the ear and larynx. Solutions containing low percentages may be used effectively, but the strength mentioned appears to be preferable.

The solution used should contain both cocaine and suprarenal extract, and should be packed in on wool for half an hour to obtain the full effect, which, in the case of the nose, is a shrunken and white mucous membrane. I have scraped both the inferior turbinates of such a nose, and sawed off a small space, without a single drop of blood escaping.

Further, in acute conditions, such as are associated with nasal and aural polypus, the use of the combined solution will allow of painless and bloodless removal. This combination diminishes poisonous effects and shock, and it greatly prolongs anaesthesia. It must be remarked, as a rule, that bleeding

sets in at the end of two hours, but this may be obviated by plugging with dried cyanide gauze immediately after the operation.

The combination of cocaine and suprarenal extract may be used with success in inflammatory conditions, and operations on the eye and other regions. It reduces the tension of the eye and produces constriction of the blood-vessels.

The local application to acute and chronically-inflamed tissues in various parts is successful in many instances.—E. A. Peters, *Brit. Med. Jour.*

Wm. Spencer, M.D.

A CASE OF HYSTERICAL APHONIA WITH VENTRICULAR BAND SPEECH.—A Jewess at the age of 16 years was terribly frightened at a "wake" by the falling of the corpse from the coffin, and was unconscious for several hours. "For two or three years she was absolutely mute." Once her normal voice was restored under ether anæsthesia. Normal interval lasting only two hours. Speaks in distinct whispers, produced by approximation of ventricular bands, while "cartilaginous glottis was wide open and the vocal processes remained apart." Galvanism, hypnotism, vocal drill, etc., was futile. But improved gradually till "talks in a deep, rough, but fairly powerful voice." She suddenly recovered after another fright from seeing a man receiving fatal injuries. The true cords, etc., act normally. The points of interest are: (1) the severity of the original shock; (2) the recovery after exposure to excitement, when all remedies had failed; and (3) the development in the course of time of ventricular band speech to replace the lost natural voice.—Middemas Hunt, *Jour. Lar., Rhin. and Otol.*

Wm. Spencer, M.D.

AURICULAR LESIONS AS A CAUSE OF AGORAPHOBIA.—In an article on the subject recording ten cases in which a dread of large open spaces was associated with vertigo, clearly due to disease of the ear, the following case is presented and is particularly interesting from the fact that, as the aural disease yielded to treatment, the agoraphobia disappeared. A man of 40, with atrophic rhinitis of twenty-five years' duration, and cicatrization of both middle ears, due to suppurative otitis in infancy. For eight years frequent attacks of vertigo, with nausea and vomiting; tinnitus aurium and marked deafness for three years. For six or eight months the symptoms of agoraphobia had been added to the others, so that the patient was unable to cross large open spaces in Paris, and even when crossing a road of more than ordinary width he would be suddenly seized with vertigo, with cold sweats, etc. In crossing a road he found it necessary to wait until a carriage passed at a walking pace, when he would take an oblique course, following the vehicle as far as possible. He was unable to go to the theatre on account of the sensation of distress caused by the space before him. He was put on a rigid milk diet on account of chronic albuminuria, but without any result with regard to the agoraphobia and vertigo. His ears were then treated by catheterization, which rapidly improved his hearing and put a stop to the vertigo.

At the end of twelve days' treatment he was able to cross the road without thinking about it, and he attributed his freedom solely to the loss of vertigo. When seen a year later he reported that the agoraphobia returned in a modified degree when the vertigo reappeared some time after the treatment.—Launois and Tarnier, *Annals des Mal. de l'Or.*

Wm. Spencer, M.D.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND
THERAPEUTICS.

SATMULI.—Gangadin, B.Sc., M.D., of Hyderabad, India, reports that the fusiform tubers of this plant, which are innumerable, are used in medicine. It can be rightly called women's friend, as its action is chiefly on the generative system of women. The following is its action on the system of females :

(1) It produces normal quantity and quality of menstrual fluid, and so cures dysmenorrhœa, vicarious menstruation, and some forms of menorrhagia.

(2) It gives great tone to the generative system of women, and so indirectly cures leucorrhœa and other vaginal discharges.

(3) It gives tone to the ovaries, and so they produce healthy and mature ovums. Owing to this, it has often been found a curative of sterility or barrenness when the cause of which was either the disordered state of the ovaries or the production of weak and immature ovums.

(4) It has the power of stimulating the lacteal glands of the female breast, and so produces more milk, because it is a medicine for agalactia.

It also gives a general tone to the whole body, and so is a most useful medicine for women in renovating their systems after parturition or nursing. If given after parturition, and continued for some time, it wonderfully strengthens the system, especially the generative, and produces enough good milk for her baby. It keeps her from becoming weak from suckling or other causes producing debility at such periods.

It is a harmless medicine, and can be used for months with profit. It is taken in doses of 30 or 40 grains, twice or thrice a day. It can be prepared in the form of fluid extract. It is much used in India by the native physicians. Its properties are enhanced by a little more use of butter.

MERCURY IN THE TREATMENT OF DIPHTHERIA.—Tooker, of Chicago, is inclined to think that *mercurius vivus* and *mercurius corrosivus* are best adapted to those incipient, incomplete or doubtful cases of diphtheria in which the prostration is not great, the exudate small, and all the symptoms indicating a mild form of the disease. The iodides of mercury are most applicable to those forms of diphtheria in which the lymphatic glands are early involved while other symptoms are of mild type. With the development of severe sore throat, a large amount of exudate and marked general symptoms, he would look to cyanide of mercury as offering the surest, quickest and best means of cure. In fact, he insists that this drug will give better results than any yet seen from antitoxin, or any other form of serum-therapy.—*Med. Era*, Oct., 1899.

F. Mortimer Lawrence, M.D.

THE THERAPEUTICS OF DIPHTHERIA.—Tooker states that when the pharynx is dull red, the tongue thickly coated, or thick and dry, *apis mel.* is better than mercury, especially if the patches of membrane are not considerable in quantity or heavy in character. The cyanide of mercury is best adapted to those cases which are intense and threatening from the beginning, and in which the tendency to membranous formation is marked from the start. It is indicated when the nares are involved; indeed, the more widespread the infection and the more intense the symptoms, the more the cyanide will prove useful. Putrescence, with foul-smelling breath and an odor that extends beyond the confines of the sick chamber, is another of its marked symptoms.

In those cases in which the urine is scanty or suppressed, and partial or general oedema is present, he has found *arsenicum alb.* of great value. In albuminuria, regardless of associated symptoms, he places great store by *arsenicum*.—*Med. Era*, Oct. 1899.

ARSENIC IN THE TREATMENT OF PLEURISY WITH EFFUSION.—Dale, of Oshkosh, Wisconsin, in looking up the history of over forty cases of exudative pleurisy, finds that in a majority of them arsenic was the only remedy given, and that in a large percentage of the remainder it was the mainstay. Thoracentesis was resorted to in less than 5 per cent. of all cases. The presumption is that in patients who recovered so promptly the effusion was of a serous or sero-fibrinous character. It cannot be reasonably claimed that arsenic or any other drug is capable of causing the absorption of pus. At the same time some of the cases presented symptoms strongly indicating the presence of a purulent effusion, and these symptoms all disappeared under the exhibition of the drug. Occasionally he has given the iodide of arsenic instead of the arsenious acid with very satisfactory results.—*Minn. Hom. Mag.*, October, 1899.

F. Mortimer Lawrence, M.D.

CIMICIFUGA FOR AMENORRHŒA.—According to his own experience, Cowperthwaite, of Chicago, would consider *cimicifuga* the most generally useful of our remedies in all classes of amenorrhœa. When perfectly indicated, its action is often marvelous, and sometimes even when not indicated. It is the drug that he usually selects when the indicated remedy fails, though in such cases he generally employs the active principle, *macrotin*. When well indicated he prefers *cimicifuga*. The drug is most useful in rheumatic, neuralgic, choreic or hysterical subjects, with menses irregular, delayed or suppressed; ovarian irritation; uterine cramps; bearing-down pains in the uterine region and small of the back; limbs heavy and torpid; suppression from cold or emotions.—*Med. Era*, September, 1899.

THE TREATMENT OF THE SEQUELÆ OF CAPILLARY BRONCHITIS.—According to Laird, phosphorus is almost specific for the hoarse, barking, croupy cough that sometimes remains after the acute symptoms have subsided. In puny, debilitated infants atelectasis does not always disappear with the cure of the original disease. In this condition there is no better remedy than sulphur. For the emphysema that often persists after a severe attack the most efficient remedies are *calcarea carb.* and chlorine. The former should be selected when the patient presents the constitutional peculiarities characteristic of this drug. In the absence of these symptoms the choice will fall upon chlorine.—*N. A. Journal of Hom.*, July, 1899.

F. Mortimer Lawrence, M.D.

CRATEGUS IN HEART DISEASE.—Gordon remarks as to the complete dearth of information concerning this new remedy in works on materia medica or therapeutics. The story of how it came to the knowledge of the profession is very interesting. It seems that one Dr. Green, of Dublin, Ireland, achieved a great reputation for the successful treatment of diseases of the heart. Patients came to him from England, the continent and all parts of the world. Many were cured, and in almost every case at least temporary relief was obtained. In his treatment of these cases he used a secret remedy. After his death instructions were found in his will to the effect that his daughter, who knew of the secret remedy and its mode of preparation, should give this knowledge to the world. It is said that his preparation was an infusion, but the writer used a tincture of the ripe berry with gratifying results in two cases of dilated heart with lost compensation, which he reports in detail.—*Clinique*, October 15, 1899.

F. Mortimer Lawrence, M.D.

APOCYNUM CANNABINUM IN A CASE OF OVARIAN TUMOR.—Dr. Oscar Hansen was consulted by a woman of 26 years, who was married, and who complained of weakness, loss of strength, slight appetite, great pain during menstruation, and frequent desire to urinate. The abdomen was increased in size, and more so on the left, with shooting pains in the left leg. Slight constipation and urine normal. On examination, a fluctuating tumor was found in the left parametrium. An ovarian tumor was suspected, and apis, hepar and bryonia were given; but as her condition gradually grew worse, she consulted a specialist, who confirmed the diagnosis and advised removal of the cyst. She refused. As no particular symptoms were present, apocynum cannabinum θ , five drops, three times a day, gradually increasing it to fifteen drops, were given. She took this remedy for about eleven months, and then it was found that the growth was about gone. Since then she has been well, and fourteen days ago no trace of the cyst was to be detected. Under the remedy, the amount of urine passed was about double that of the normal.—*Homæopatisk Tidsskrift*, No. 12, 1898.

Frank H. Pritchard, M.D.

IODIUM IN CATARRH OF THE BILE-PASSAGES.—Dr. Oscar Hansen was consulted by a fireman of twenty-seven years, who every year for three years had suffered for three weeks from pressing, burning pains in the right hypochondrium which radiates up towards the right shoulder, across the abdomen and often into the back. His appetite was good. These pains *either wholly disappear, or are greatly relieved by lying on the left side*. No enlargement of the liver nor jaundice. Iod. and phos. were seemingly indicated (Benninghausen). Iod. 2x, five drops, four times a day. In one week no improvement. Iod. 3x in the same manner. In one week more the pains had disappeared. The remedy was continued in the same dose, but at longer intervals; since then he has been well.—*Homæopatisk Tidsskrift*, No. 12, 1898.

Frank H. Pritchard, M.D.

GRAPHITES IN CHRONIC ECZEMA OF THE PALMS OF THE HANDS.—Dr. Oscar Hansen observed a porter of sixty-one years, who for a year and a half had suffered from a chronic eczema of the palms of both hands, which skin was in patches and red, thickened and desquamating. It itched and burned greatly in the evening after getting warm in bed. It was greatly aggravated by scratching. Ars. and a salve of merc. precipitat. ruber externally only re-

lieved when graphites 2x was given three times a day, in five-grain doses, with a salve of powdered and lard graphites, 1 : 12, locally. In two months the hands were wholly cured and smooth. He had been under allopathic treatment without the slightest benefit.—*Homœopatisk Tidskrift*, No. 12, 1898.

Frank H. Pritchard, M.D.

ZINCUM CYANATUM IN PETIT MAL.—Dr. Oscar Hansen was consulted with regard to a young girl of twelve years, who for one and a half years had been epileptic. Her arms would twitch, and she would drop what she had in her hands. At the same time her head would fall backwards and her eyes turn upwards. These attacks occurred most frequently when she would sit still and read, lasted one minute, and consciousness was lost for this period. Several attacks daily. During the seizures her face was pale. Her memory was good. Her urine was normal and often contained a great deal of urates. Her functions were regular. Wine aggravated her condition. Zinc cyanatum 2x was administered, five grains, three times a day. The attacks decreased in frequency, and in less than three months the twitching in the arms had disappeared, and that of the head still less. In four months more there were only a few twitches of the head, and without loss of consciousness in the morning, and as two months further use of this drug did not improve matters, and as it was noted that the twitching disappeared during movement, and especially in the open air, puls. nigric. 3c. was given, three drops, three times a day, and in one month more she was wholly restored to health.

Frank H. Pritchard, M.D.

PHOSPHORUS IN PURPURA HÆMORRHAGICA.—Dr. Oscar Hansen recently saw a girl of ten years who had been sick for five weeks, and had been treated with ferruginous preparations, without success. The disease began with loss of appetite and pains in the stomach, but as soon as the disease had developed the appetite returned, and the gastralgia disappeared. On both thighs and legs there was an eruption which consisted of bluish-red and oval spots, situated on the inner sides where they formed large groups—ecchymoses. Otherwise she was well; no hæmorrhages from the gums, lungs, or other organs. Phosphor. 2c. dil., three drops, three times a day, was administered, and in three weeks she was entirely well. All the eruption had disappeared.

Frank H. Pritchard, M.D.

MERCURIUS PRECIPITATUS RUBER IN ECZEMA MADIDANS OF THE BACK OF THE NECK.—Dr. Oscar Hansen was consulted with regard to a girl of twelve years, who for three months had had on the occiput, the back of the neck and around towards the front of the throat, an itching and oozing eruption which was covered with a scab which crusted the hair together. The cervical glands on both sides of the neck were enlarged, swollen and hard. The exuding secretion was purulent. Otherwise she was well. Merc. precipitat. ruber 2x, five grains, three times a day, and locally the eczematous spot was ordered washed with lanolin soap and lukewarm water each morning, after which an unguent of the same drug in lard, 1 : 40, was applied, as well as in the evening. In fourteen days the eruption was less and drier, with no itching. The eczema became dry, desquamating, and wholly disappeared in two months.

Frank H. Pritchard, M.D.

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